

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>B-652 72 02501 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02501</p>	
<p>BIRTH NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) <i>Frances A. Byrnes</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>2. DATE AND HOUR OF DEATH <i>March 9, 1972</i> <i>8 A.M.</i> M.</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Harbor View Nursing Home</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2302</i></p>	
<p>5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <i>June 16, 1888</i> 9. AGE (In years last birthday) <i>83</i></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>		<p>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></p>	
<p>13. FATHER'S NAME <i>Casper Haas</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Catherine Haas</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i></p>		<p>16. SOCIAL SECURITY NO. <i>212-22-2930 D</i></p>	
<p>17. INFORMANT <i>Helen Wroten</i> ADDRESS <i>48 E. Fort Ave.</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>18. <i>4/12.4 I</i> CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE <i>Cardiac arrest</i></p>	
<p>ANTECEDENT CAUSES</p>		<p>DUE TO, OR AS A CONSEQUENCE OF: <i>A.S.C.U.D</i></p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic - Senility</i></p>	
<p>(C) <i>Chronic - Senility</i></p>		<p><i>7</i></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>schizophrenia</i></p>		<p><i>7</i></p>	
<p>19A. DATE OF OPERATION _____</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>	
<p>20A. AUTOPSY? (Yes or No) _____</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>		<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) _____</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>July 1970</i> to <i>March 9, 1972</i> that (I) (we) last saw the deceased alive on <i>3/5/72</i> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>K. Krulovitz MD</i> DEGREE _____</p>		<p>23B. DATE SIGNED <i>3/10/72</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>Kenneth Krulovitz MD</i> DEGREE _____</p>		<p>23D. ADDRESS <i>115 W. Monument St. Balto, Md.</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>3/13/72</i></p>	
<p>24C. NAME of CEMETERY or CREMATORY <i>Holy Cross Cemetery</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1972</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Kelly, R.D.</i></p>	
<p>25C. FUNERAL DIRECTOR <i>McCully Funeral Home</i></p>		<p>ADDRESS <i>130 E. Fort Ave.</i></p>	

1075 SS

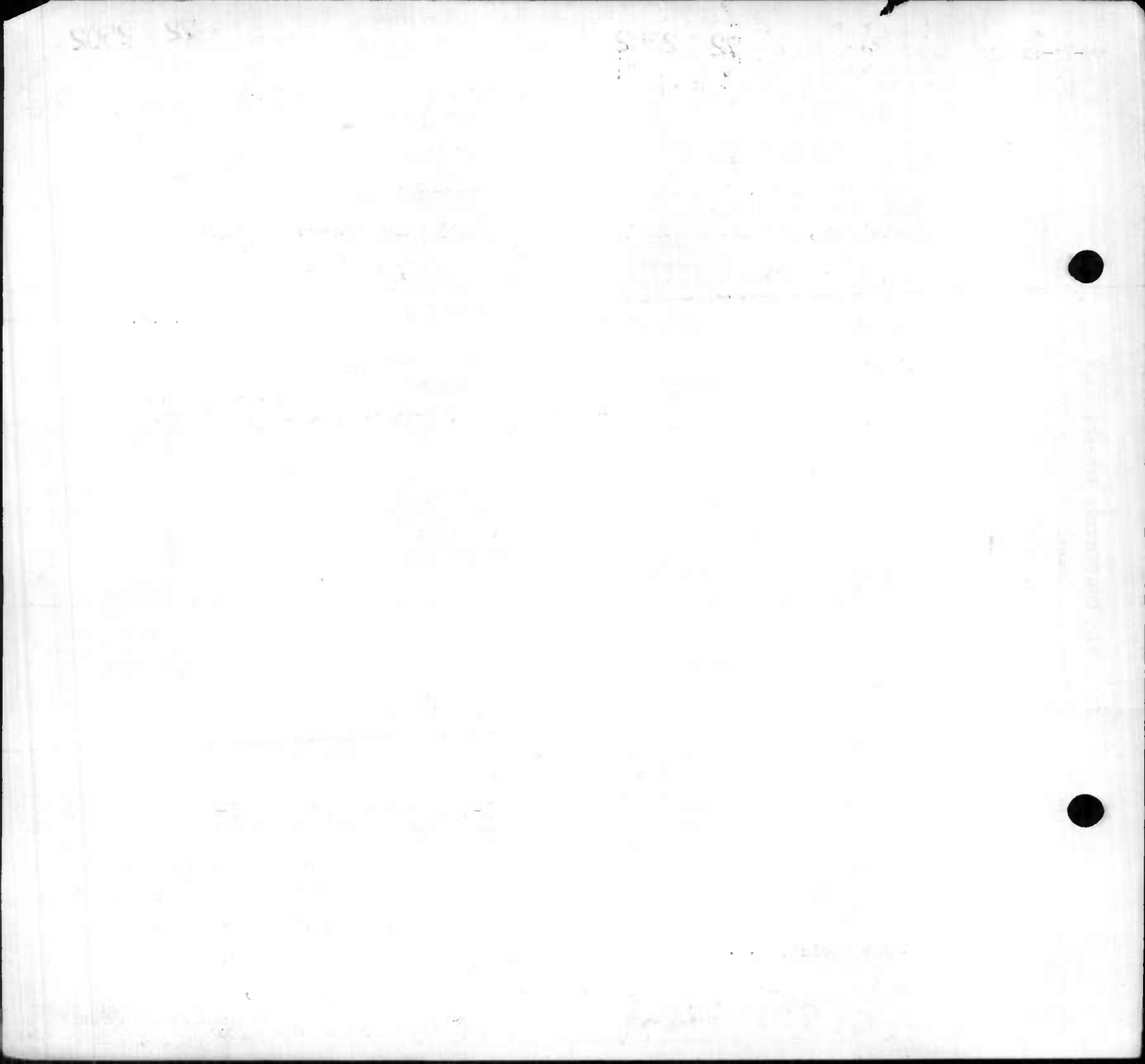
1075 SS

1075 SS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02502
BIRTH NO. 72-04200		72 02502 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Baby Girl Donna Rae Pumphrey		2. DATE AND HOUR OF DEATH 3/9/72 11218 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 14940 Eastern Avenue Baltimore Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2303 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1733 Olive Street 21230		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1972	9. AGE (In years last birthday) - If Under 1 Yr. Months: 2 Days: 2 Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Thomas Pumphrey		14. MOTHER'S MAIDEN NAME Donna Breighner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland
18. 759.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cervical cord DUE TO, OR AS A CONSEQUENCE OF: 1. Severe disorder 2. ? CNS malformation (B) DUE TO, OR AS A CONSEQUENCE OF: 1. neonatal asphyxia 2. ? Torsion (C) DOF 3. Severe dysmaturity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Small right pneumothorax		4 hrs.		
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3-7-1972 to 3-9-1972 that (I) (we) last saw the deceased alive on 3/9-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. March M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/9/72
23C. PHYSICIAN'S NAME (Type) Joel Varian M.D.		23D. ADDRESS 14940 Eastern Avenue Baltimore City Hospitals		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-10-72		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park
24D. LOCATION Glen Burnie, Maryland		24E. (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR W. E. Kelly		25C. FUNERAL DIRECTOR McGully Funeral Home
25D. ADDRESS 130 East Fort Avenue		25E. CITY, STATE, ZIP Baltimore Md 21230		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02503 CERTIFICATE OF DEATH				REG. NO. 72 02503	
1. NAME OF DECEASED (Type or Print) Miller, William S			2. DATE AND HOUR OF DEATH March 9, 1972 11:30 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2646		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN Baltimore 71224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 8/30/06		9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL CLERK			10B. KIND OF BUSINESS OR INDUSTRY FOOD PRODUCE		11. BIRTHPLACE (State or foreign country) Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William S. MILLER		
14. MOTHER'S MAIDEN NAME Jennie GRAVES			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		
16. SOCIAL SECURITY NO. 016 10578569A			17. INFORMANT BCH Records - 4940 Eastern Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 199.1 I			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE adeno Ca DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). COPD GI Lobster					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. Lardou			23B. DATE SIGNED 3/9		
23C. PHYSICIAN'S NAME (Type) Dr. L. Lardou M.D.			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue		
24A. BURIAL CREMATION REMOVAL (Specify) CREATION		24B. DATE 3/11/72		24C. NAME OF CEMETERY OF CREMATORY LOUDBON (BRADLEY?)	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.					
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert E. Miller		25C. FUNERAL DIRECTOR W. R. Bradley, D.D., M.D.	

Wants

March 12, 1920

L. G. L.

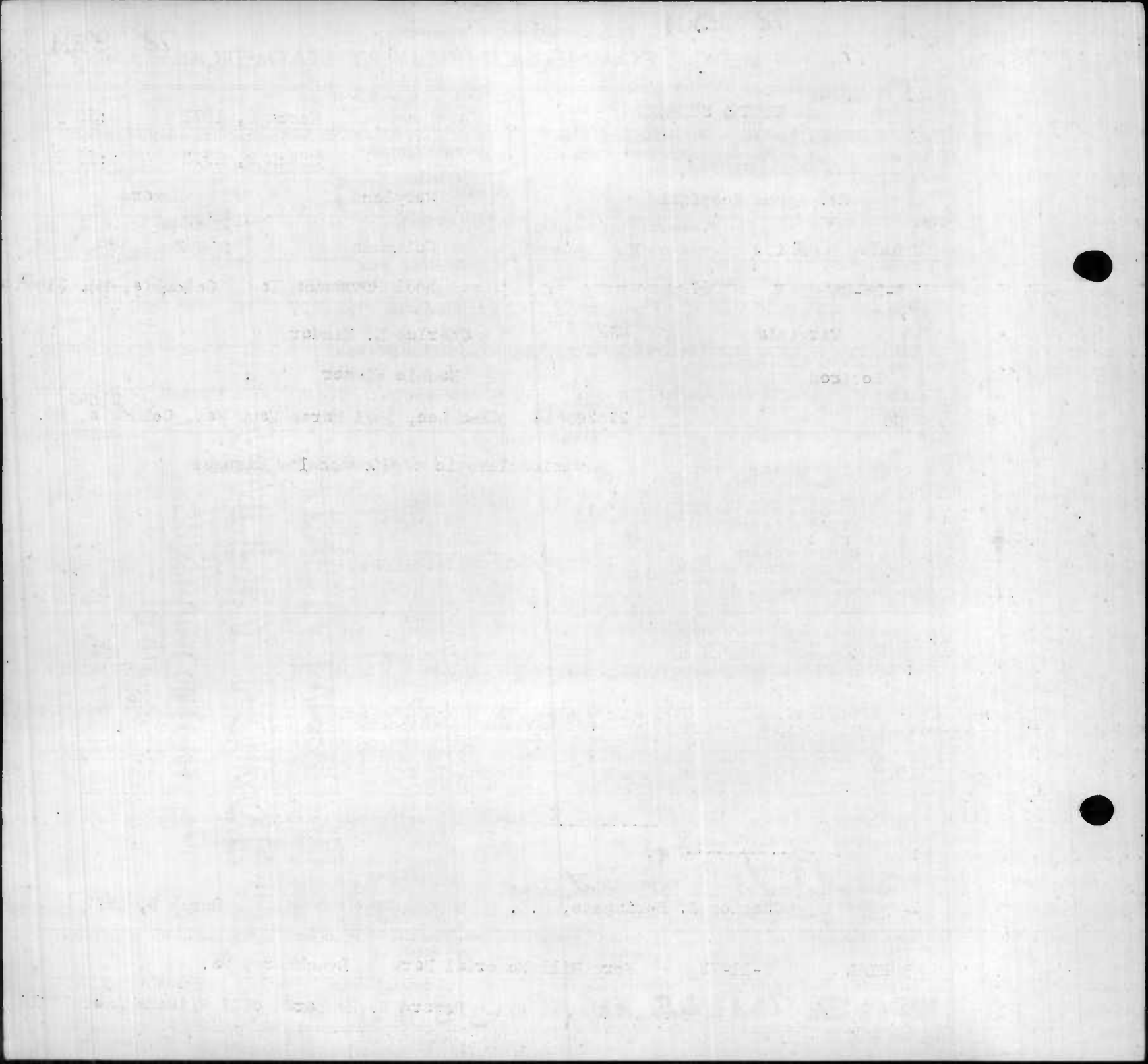
S-362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

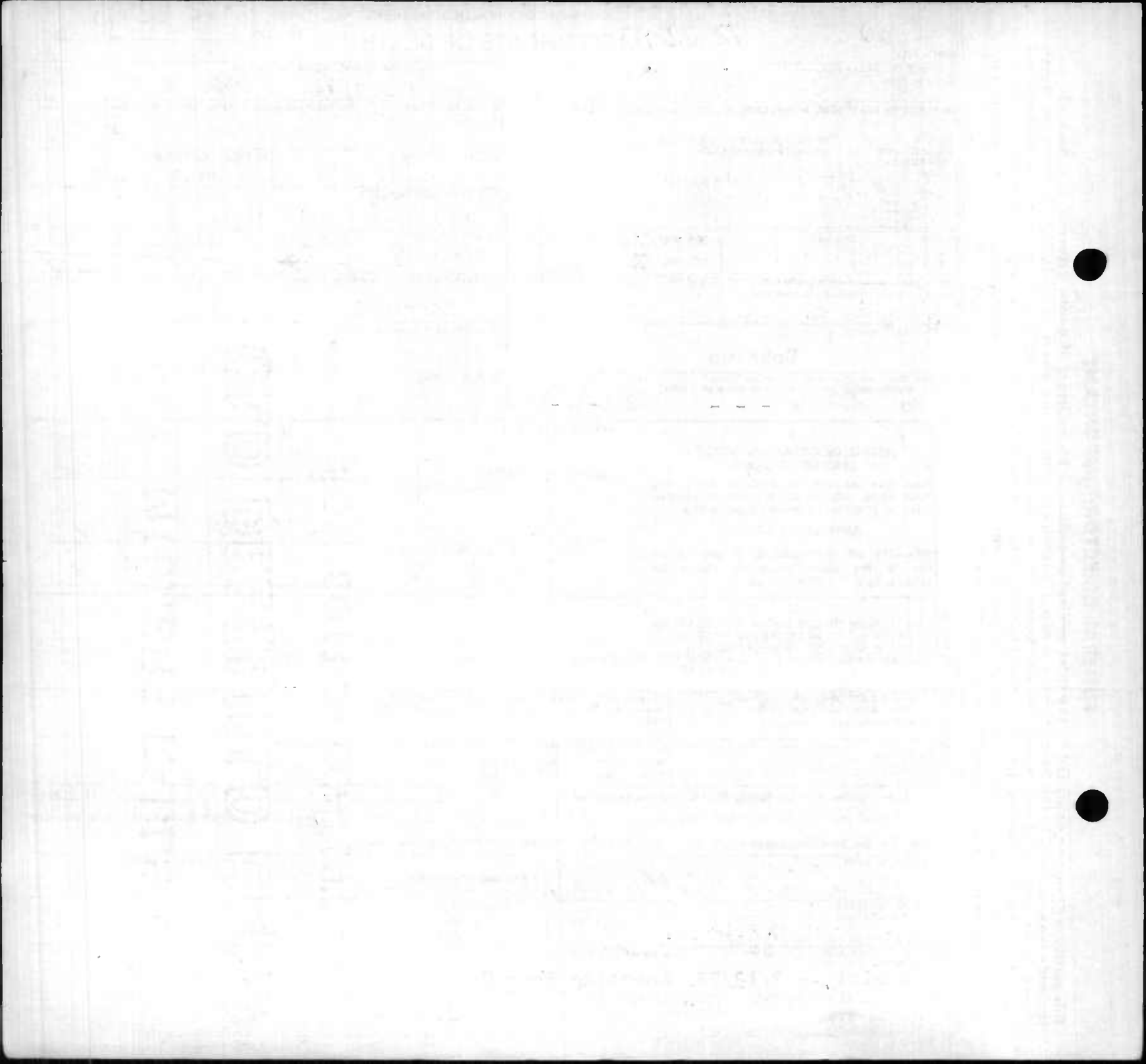
1. NAME OF DECEASED (Type or Print) THELMA STOWERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 8, 1972 8:59 P M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1972 8:59 P M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-26-04		10. AGE (In years lost birthday) 67 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L. Kinder		14. MOTHER'S MAIDEN NAME Nannie Wimmer	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. 228223644	
19. INFORMANT Alma Lee		20. ADDRESS 21045 5471 Marsh Hawk Way, Colombia, Md.	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 9, 1972 ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-11-72	
24C. NAME of CEMETERY or CREMATORY Fort Hill Memorial Park		24D. LOCATION (City, town, or county) (State) Lynchburg, Va.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Charles E. [illegible]	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

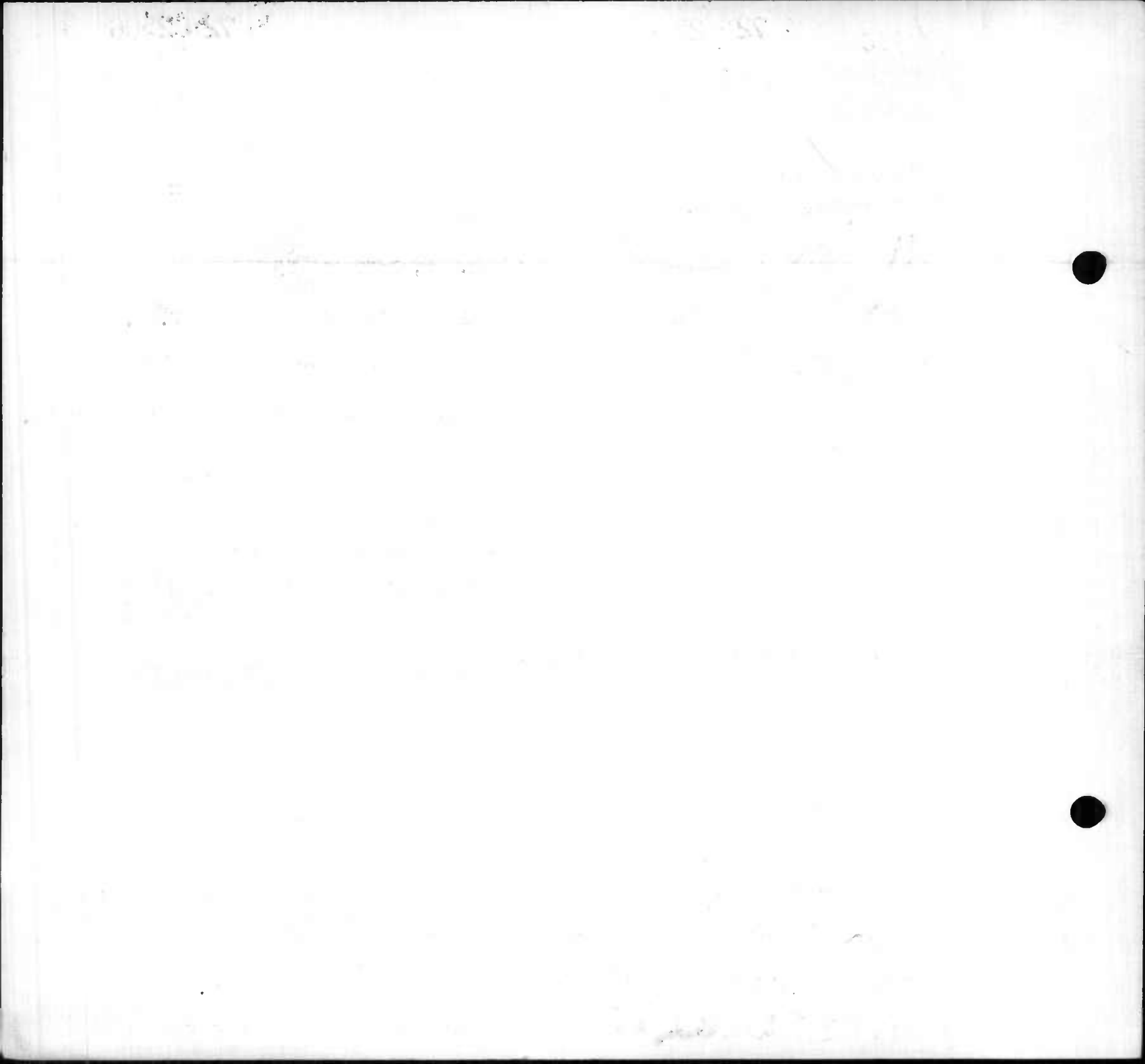
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
S-400		72 02505		72 02505
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Seal, Bertha M.</u>		
2. DATE AND HOUR OF DEATH <u>3/9/72 2:15 PM</u>		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1307</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u> <u>33</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>3939 Roland Ave.</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/99</u>	9. AGE (In years last birthday) <u>72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Bohltz</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-5435</u>		17. INFORMANT <u>Betty Bosley</u>
ADDRESS <u>622 Graftside Ave Baltimore, Md.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>038.9 I</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pulm. congestion 2° to sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Septicemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4 day</u> <u>6 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2/1/72</u> 19 <u>72</u> to <u>3/9/72</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>3/9/72</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Randolph M. Hower M.D., Ph.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/9/72</u>
23C. PHYSICIAN'S NAME (Type) <u>Randolph M. Hower M.D., Ph.D.</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/13/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>
24D. LOCATION <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1972</u>		25B. NAME OF REGISTRAR <u>R. E. E. E. E.</u>		25C. FUNERAL DIRECTOR <u>Anderson Funeral Home</u>
ADDRESS <u>8 - Haddon</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		72 02506		BALTIMORE CITY HEALTH DEPARTMENT		72 02506	
BIRTH NO.		72 02506		CERTIFICATE OF DEATH		W	
1. NAME OF DECEASED (Type or Print)				DATE AND HOUR OF DEATH			
HALEY LAWRENCE				3.7.72 at 1200 noon P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
University Hospital Green Street Baltimore MD				MD Dorchester 5900			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W				Jan. 29, 1907	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Barber		Self		Hallwood Virginia		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Irving Haley				Daisy Ross Haley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
unknown				Nancy James Haley 302 Somerset Ave Cambr.			
18. 441.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Shock. Irreversible. Intraabdominal bleeding from leak in forniculae by Pan (B) DUE TO, OR AS A CONSEQUENCE OF: Abdominal aortic aneurysm Ruptured (C) -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 3-7-72 19 that (I) (we) last saw the deceased alive on 3-7-72 19 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Bilal Qureshi				3.7.72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. BILAL QURESHI				SHOCK TRAUMA UNIT University Hospital Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/11/72		Cambridge Cemetery		Cambridge Dor. MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 13 1972		[Signature]		Lescompte		Funeral Home Cambridge MD	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) DONALD JAMES HASTINGS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 3 8 72 10:35 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 POLICE BOAT GAITHER 800 Blk. Lancaster Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1972 10:35 A.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1338	
9. DATE OF BIRTH Aug. 6, 1936		10. AGE (In years last birthday) 35	
11. BIRTHPLACE (State or foreign country) DISTRICT of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RALPH HASTINGS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body & Tender Repair	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 17 May 56	
17. SOCIAL SECURITY NO. 212-34-2572		18. INFORMANT ADDRESS Dunkin Miller - 518 E. 75th St.	
19. CAUSE OF DEATH E 910.9 I Drowning		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Water		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2900 Blk. Falls Road 1305	
22D. TIME OF INJURY (APPROX.) 2-3-72 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Drowning		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/8/72	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 3-10-72	
24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert E. [illegible]	
25C. FUNERAL DIRECTOR Donovan Funeral Home		ADDRESS 3818 Roland Ave.	

1

72 02508

BALTIMORE CITY HEALTH DEPARTMENT

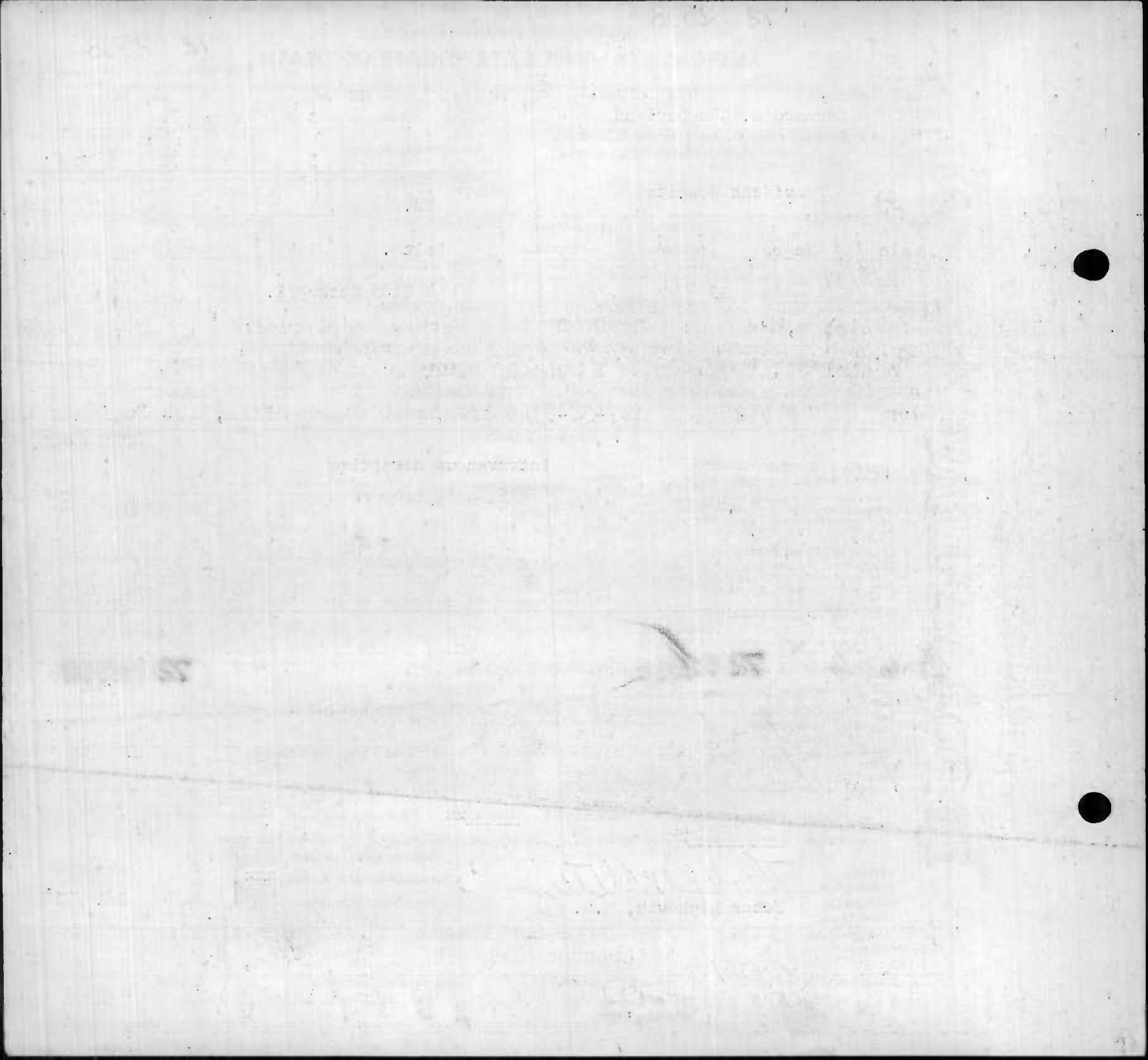
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02508

REG. NO.

BIRTH NO.

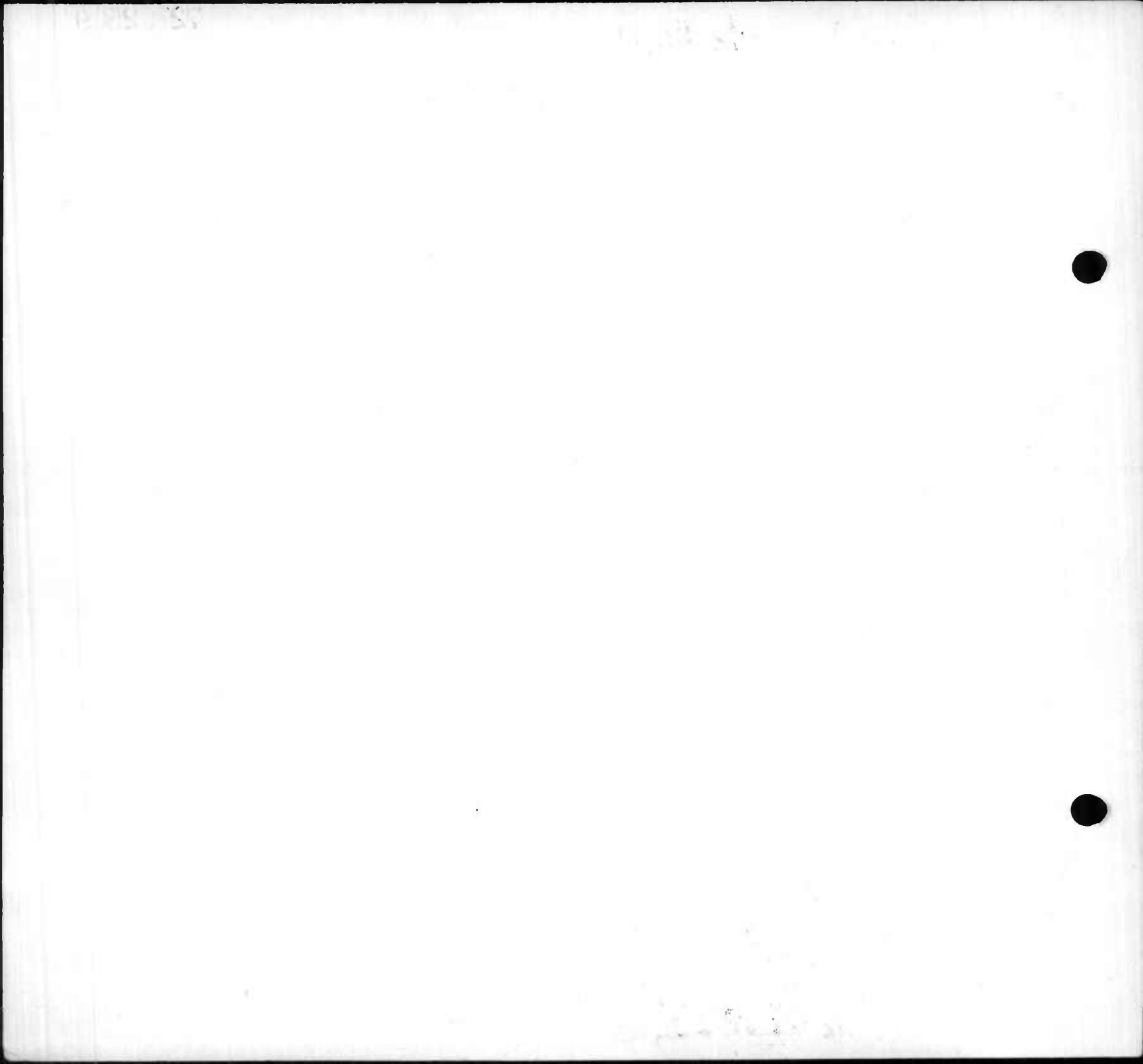
1. NAME OF DECEASED (Type or Print) Chamberlain Bernard E. Chamberland		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 9 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 9 72 8:08 p. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1302			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2/8/37		10. AGE (In years last birthday) 35	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Mathew Chamberlain		14. MOTHER'S MAIDEN NAME Louise	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School		16. KIND OF BUSINESS OR INDUSTRY G I School	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		18. SOCIAL SECURITY NO. 217-34-3346	
19. INFORMANT Mr Malcomb Chamberlain		ADDRESS 3100 St Lukes Lane	
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 3/10/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Adolphus Halstead	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

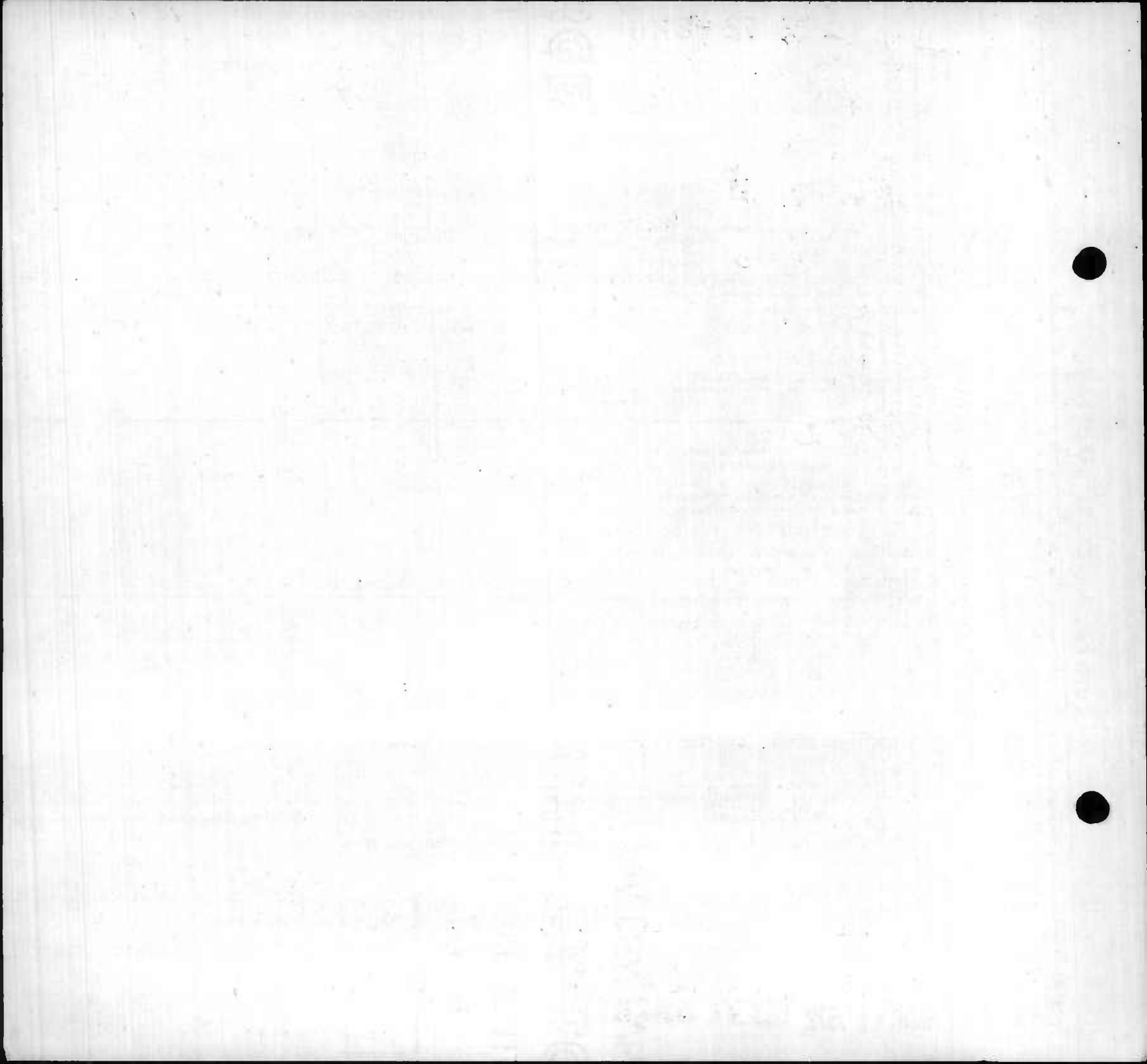
B-620		72 02509		BALTIMORE CITY HEALTH DEPARTMENT		72 02509	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print) <u>BRISCOE, VERDERA Verdina 1</u>				2. DATE AND HOUR OF DEATH <u>7 MARCH 72, 9:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MD. HOSPITAL</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1200 McCulloch ST.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>32</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>PLUMMER LYNCH</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>FATHER</u>		ADDRESS <u>SAME</u>	
18. <u>42794303.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>REFRACTORY VENTRICULAR TACHYCARDIA</u> <u>? ETIOLOGY</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <u>?</u>				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7 MAR 1972</u> to <u>7 MAR 1972</u> that (I) (we) last saw the deceased alive on <u>7 MAR 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>P.A. Mackowiak</u>				23B. DATE SIGNED <u>3/7/72</u>		23C. PHYSICIAN'S NAME (Type) <u>P.A. Mackowiak</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/13/72</u>		24C. NAME of CEMETERY or CREMATORY <u>M. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR <u>A. Halstead</u>		ADDRESS <u>1206 W. North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. _____	
1-652		72 02510		72 02510	
1. NAME OF DECEASED (Type or Print) JACK DRINKARD		2. DATE AND HOUR OF DEATH 3-9-72 7:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 522 N Chapel Street		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 604 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 522 N. Chapel St.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-16	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington Co., Georgia	
13. FATHER'S NAME Ollie Drinkard		14. MOTHER'S MAIDEN NAME Grunny Devore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 259-10-9601		17. INFORMANT Pth. old Chart ADDRESS _____	
18. 4/12.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE 5th CVA - thrombotic DUE TO, OR AS A CONSEQUENCE OF: (B) HASCU DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension - Chronic - Uncontrolled		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate years years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-6-1972 to 2-15-1972 , that (I) (we) last saw the deceased alive on 2-15-1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Walter Nathan Malloy, M.D. DEGREE				23B. DATE SIGNED 11 March 1972	
23C. PHYSICIAN'S NAME (Type) WALTER NATHAN MALLOY M. D.		23D. ADDRESS BOX 322 JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/72		24C. NAME OF CEMETERY or CREMATORY St. Auburn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md		(State) _____			
25A. DATE REC'D BY HEALTH DEPT. MAR 18 1972		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave	



W-425

72 02511' BALTIMORE CITY HEALTH DEPARTMENT

72 02511'

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Della Wilson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 2 Day 11 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2014 E. Pratt Street		3. DATE PRONOUNCED DEAD Month 2 Day 11 Year 72 Hour 3:55 p.m.	
6. SEX female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5/9/13		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS LISTER		14. MOTHER'S MAIDEN NAME ?	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. 224-12-6144	
19. INFORMANT BETTY WELLS		ADDRESS 1142 FOXWOOD LANE	
19. CAUSE OF DEATH 4/2.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 2/12/72			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 2/12/72	
24C. NAME OF CEMETERY or CREMATORY RICHLANDS		24D. LOCATION (City, town, or county) (State) RICHLANDS VA.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR JOJO CONNELLY	
25C. FUNERAL DIRECTOR 300 MACE		ADDRESS	

1175 57

1175 57

B-300

72 02512

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02512
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILTON JEROME BEATTY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 Hutton Avenue and Weatherville Rd Leakin Park		3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1972 6:40 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN ? Balto	
9. DATE OF BIRTH June 29, 1947		10. AGE (In years last birthday) 24 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray, and M. Beatty		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		16. KIND OF BUSINESS OR INDUSTRY Cab Driver	
17. MOTHER'S MAIDEN NAME Edith Winsboro		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
19. SOCIAL SECURITY NO. 275 48 2007		20. INFORMANT Raymond M. Beatty	
21. ADDRESS 612 Wood Street 21225		22. CAUSE OF DEATH Gunshot wounds of head and chest	
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 965X		24. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		26. DUE TO, OR AS A CONSEQUENCE OF:	
27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
29. DATE OF OPERATION 2		30. CONDITION FOR WHICH OPERATION WAS PERFORMED	
31. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Leakin Park	
33. WHERE DID (If in Baltimore City, give exact location) Hutton Ave. and Weatherdsville Road		34. INJURY OCCUR?	
35. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) March 7-8, 1972 ? m.		36. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
37. HOW DID INJURY OCCUR? Found in park		38. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/8/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/11/72	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Dorsey Road Dorsey Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.	
25C. FUNERAL DIRECTOR McGally Funeral Home		25D. ADDRESS 237 Papatpsco Ave	

N 854.1

1912



1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-624		72 02513		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02513	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>Parsley, Hugh</u>				2. DATE AND HOUR OF DEATH <u>March 7, 1972</u> <u>4:20</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Balt. Inc.</u>				A. STATE <u>Md.</u> B. COUNTY <u>Balto., Co.</u>			
				C. CITY OR TOWN <u>Woodlawn</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>2118 Lorraine Ave.</u> <u>21207</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-90</u>	9. AGE (in years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grave digger</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>? Parsley</u>				14. MOTHER'S MAIDEN NAME <u>? Day</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>212 12 2791</u>		17. INFORMANT ADDRESS <u>Mr George A. Reed 2110 Lugine Ave 21207</u>			
18. <u>436.7</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u></u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>1 month</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2-10-</u> 19 <u>72</u> to <u>3-7-</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3-7</u> 19 <u>72</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jack Pollock</u>				23B. DATE SIGNED <u>March 7, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>M. R.</u>	
23D. ADDRESS <u></u>				23E. FUNERAL DIRECTOR <u>John T. Stansbury</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>3-11-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>6411 Windsor Mill Rd.</u>			

MS. S. 13

MS. S. 13

MS. S. 13

MS. S. 13



1

B-650 72 02514

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02514

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM R. BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 7, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour March 7, 1972 10:48 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Ellicott City, Md.	
9. DATE OF BIRTH Aug, 9, 1938		10. AGE (in years lost birthday) 33	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		14B. KIND OF BUSINESS OR INDUSTRY ALEX & ALEX INS. CO	
15. MOTHER'S MAIDEN NAME Vina Palmer		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 401-56-6594		18. INFORMANT Mrs. William R. Brown Sr.	
19. E911X		ADDRESS 21043 9613 Longview Dr.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration of Chewing Gum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) National Guard Armory	
26. TIME (Month) (Day) (Year) (Hour) 3-7-72 P. m.		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Ellicott City, MD.	
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		29. HOW DID INJURY OCCUR? Aspirated while playing basketball	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/10/72	
24C. NAME OF CEMETERY or CREMATORY Crestlawn		24D. LOCATION (City, town, or county) (State) Ellicott City, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Witzke, 1630 Edmondson Avenue 21228	
25C. FUNERAL DIRECTOR		ADDRESS	

VS 151-REV. 1/1/68

N 933X

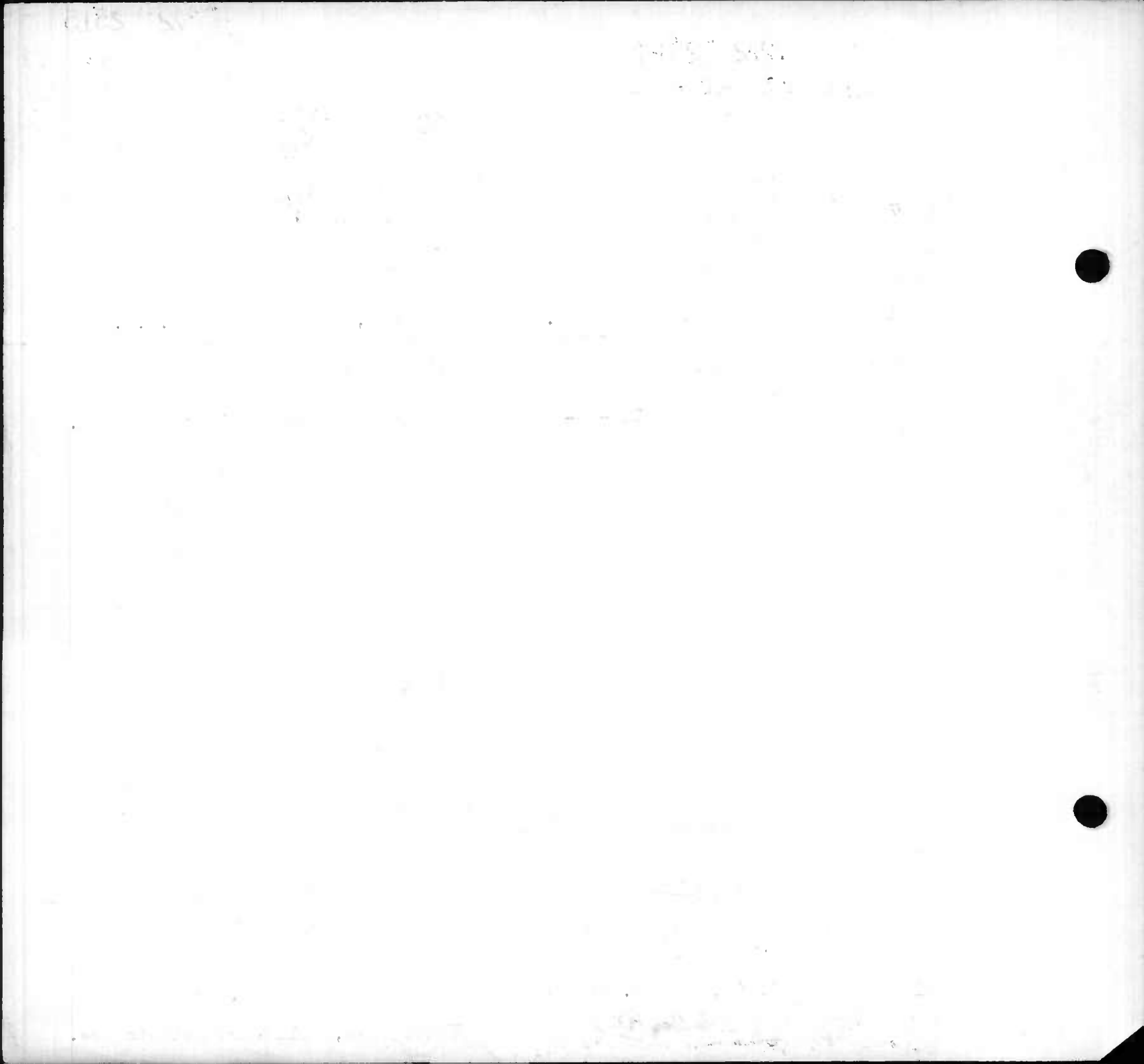
3-22-1972 - Completion of cause of death on a pending medical examiner death certificate

Ronald N. Kornblum, M.D.
Assistant Medical Examiner
HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02515		72 02515	
BIRTH NO.		72 02515		REG. NO.	
1. NAME OF DECEASED (Type or Print) CHESTER EDGAR L.			2. DATE AND HOUR OF DEATH 3/10/1972 at 12:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital 730 Ashburton Baltimore, Md. 21216			A. STATE Md. B. COUNTY 21216		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2303 Rosedale St.					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/12/12	9. AGE (In years last birthday) 59 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10B. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Edgar Chester			
14. MOTHER'S MAIDEN NAME Sadie Clark		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-09-6002		17. INFORMANT ADDRESS Gwendolyn Chester 2303 Rosedale St.			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 533.91 Acute Pulmonary Edema					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (b) DUE TO, OR AS A CONSEQUENCE OF: (c) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Multiple bleeding peptic Ulcers. 2 days					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/9/72 19 to 3/10/72 19 that (I) (we) last saw the deceased alive on 3/10/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE m. Dongre				23B. DATE SIGNED 3/10/1972	
23C. PHYSICIAN'S NAME (Type) DR. DONGRE				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 3/15/72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR ADDRESS Kenneth Law, 4611 Park Heights Ave.			
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert L. Law		25C. FUNERAL DIRECTOR ADDRESS Kenneth Law, 4611 Park Heights Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Theresa Johnson				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 6 72			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1830 Druid Hill Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 6 72 3:58 p.			
6. SEX female				7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-21-53				10. AGE (In years last birthday) 19		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Clarence Johnson		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1402	
15. MOTHER'S MAIDEN NAME Mozelle White				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. None				18. INFORMANT ADDRESS Mozelle White 701 Mulberry St. Apt. 305			
19. E 965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Shotgun wound of chest				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20. DATE OF OPERATION 2				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOUSE			
22C. WHERE DID INJURY OCCUR? 1830 Druid Hill Avenue				22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3 6 72 3:50 p.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subject shot during altercation			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)				DATE SIGNED 3/7/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/11/72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert C. [illegible]		25C. FUNERAL DIRECTOR Kenneth Law		ADDRESS Funeral Chapel, 4611 Park Heights Ave	

17

18

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

1015

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02517	
BIRTH NO. Cecil Co. Md. 72 02517				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HALL, ARTHUR D., JR.			2. DATE AND HOUR OF DEATH 3-3-72 12:07 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND C. CITY OR TOWN ELKTON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RD#5 BOX 199		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/15/71		9. AGE (In years last birthday) 11MO
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10B. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME HALL, SR. ARTHUR			14. MOTHER'S MAIDEN NAME ADAMS, ARLENE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ----		17. INFORMANT ADDRESS Arthur D. Hall, Elkton, Md. R.D.# 5	
1B. 741.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Surgical procedure - Meningocele				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min. 2 hours life	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYDROCELE				life	
19A. DATE OF OPERATION 3-3-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MENINGOCELE		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21D. TIME OF INJURY (APPROX.) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> NO Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO	
22. I certify that (I) (this hospital) attended the deceased from 27 February 1972 to 3 March 1972 and that (I) (we) last saw the deceased alive on 3 March 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karl Stecher Jr.				23B. DATE SIGNED 3 March 1972	
23C. PHYSICIAN'S NAME (Type) DR. KARL STECHER JR.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/7/72		24C. NAME OF CEMETERY or CREMATORY Cherry Hill Methodist Cemetery, Cherry Hill, Md.	
24D. LOCATION (City, town, or county) (State) Cherry Hill, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972			
25B. NAME OF REGISTRAR Blaine E. Taylor, Jr.		25C. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.			

1025 35

1025 35



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		72 02518		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02518	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRANK PARKS				2. DATE AND HOUR OF DEATH 3/10/72 12:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1401			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD. GENERAL HOSPITAL				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 259 ROBERT ST.							
5. SEX M	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CONTRACTORS		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 283-12-1445		17. INFORMANT ADDRESS EVELYN PARKS - 259 ROBERT ST			
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) cardiac arrest due to myocardial infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins - 2 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiac arrest due to myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/6 19 72 to 3/10 19 72 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eligah S. Sander				23B. DATE SIGNED 3/13/72		23C. PHYSICIAN'S NAME (Type) ELIGAH SANDER	
23D. ADDRESS 2300 GANNON BLVD.				23E. DATE SIGNED 3/13/72			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/15/72		24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR DR. J. H. HARRIS		25C. FUNERAL DIRECTOR CHATMAN FUNERAL HOME		25D. ADDRESS 1701 N. E. CULLEN ST. BALTO. MD.	

FRANK PARKS

3/15/32

ALD

10447

2nd Regiment

Mr. General Hospital

41 Need

11/2/32

U.S.A.

CHIC

Contractors

Leaves

Unknown

Unknown

113 N. 1st St. East, St. Louis, Mo.

ALD

General 3/15/32 Mr. Parks

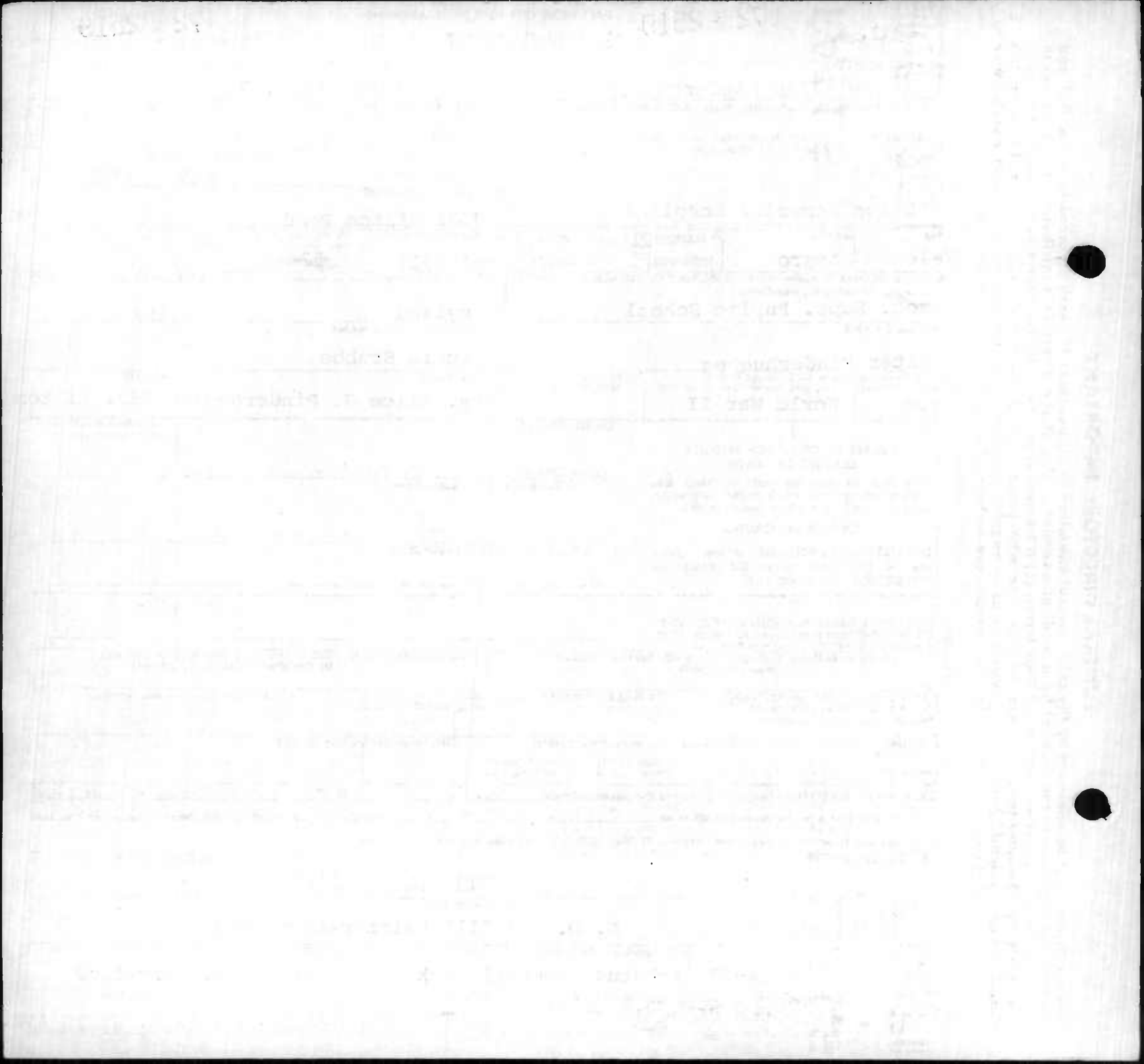
ALD

Contractors

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

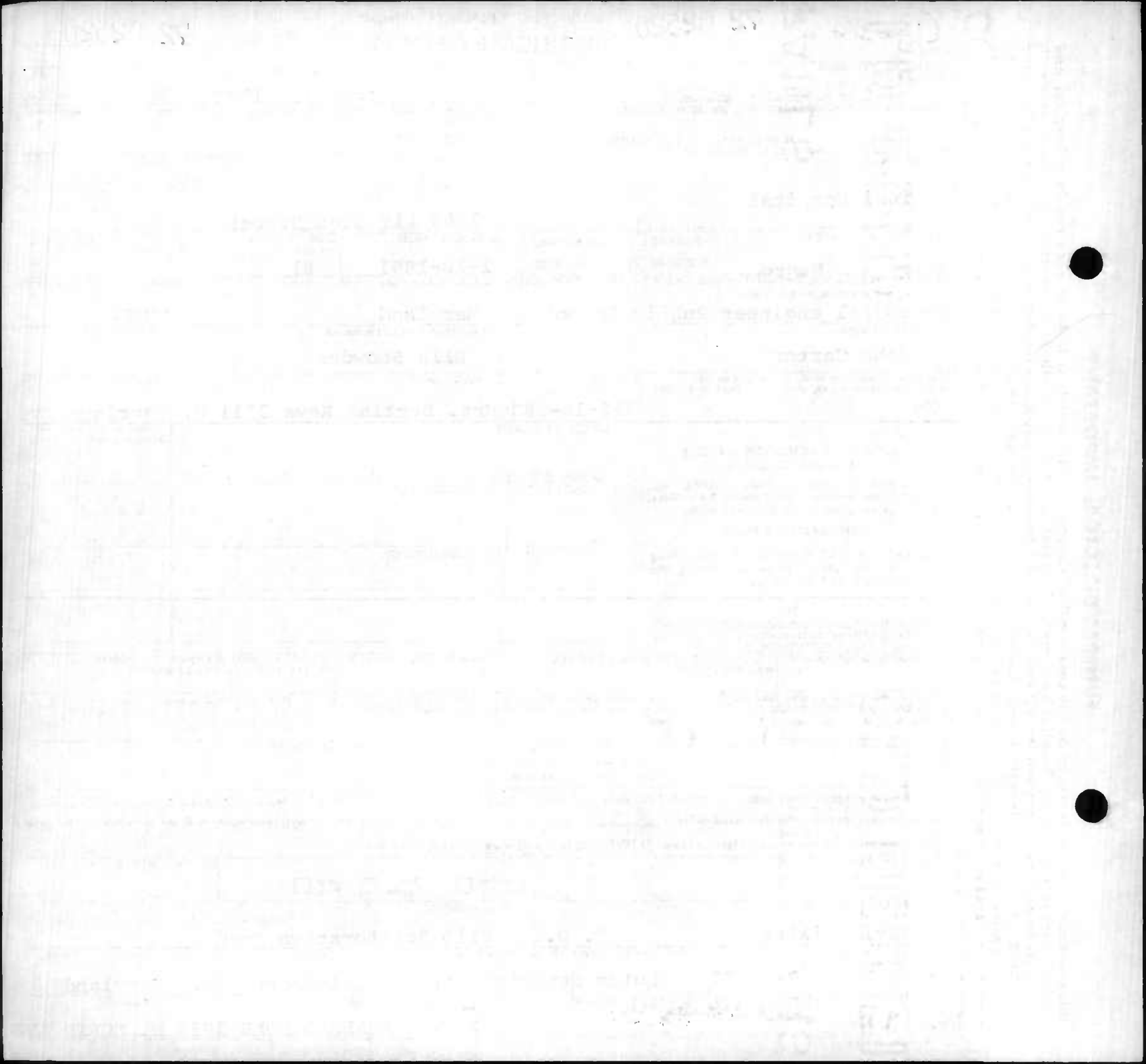
<div style="display: flex; justify-content: space-between;"> P-536 72 02519 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02519	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William Pinderhughes			
2. DATE AND HOUR OF DEATH March 10, 1972		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1511			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3521 Hilton Road			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-1919	9. AGE (in years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assoc. Supt. Public School		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter Pinderhughes		14. MOTHER'S MAIDEN NAME Lucia Stubbs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Alice G. Pinderhughes 3521 Hilton	
18. 4-10-9-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) A.therosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes unknown	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 71 to March 10 19 72 that (I) (we) last saw the deceased alive on Feb 26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David D. Miller				23B. DATE SIGNED March 13-1972	
23C. PHYSICIAN'S NAME (Type) David Miller		23D. ADDRESS M. D. 9115 Reisterstown Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-636 72 02520 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02520	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) William H. Carter			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital		2. DATE AND HOUR OF DEATH March 11, 1972			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1403		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-18-1891 9. AGE (in years last birthday) 81 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodial engineer		10B. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Carter 14. MOTHER'S MAIDEN NAME Ella Snowden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-9830		17. INFORMANT ADDRESS Mrs. Bertina Keys 3711 W. Garrison Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from Aug 1969 to March 11 1972 that (I) (we) last saw the deceased alive on March 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Miller				23B. DATE SIGNED March 13, 1972	
23C. PHYSICIAN'S NAME (Type) David Miller		23D. ADDRESS M. D. 9115 Reisterstown Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972			
25B. NAME OF REGISTRAR David E. Miller, M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-256		72 02521		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02521	
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Cephas J. Bazemore				March 10, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital				A. STATE Maryland		B. COUNTY 1605	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
48				E. STREET AND NUMBER 822 Whitmore Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1920	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintance		10B. KIND OF BUSINESS OR INDUSTRY U. S. Post Office		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jefferson Bazemore				14. MOTHER'S MAIDEN NAME Esther Bazemore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO. 237-24-4359		17. INFORMANT ADDRESS Mrs. Rosetta Bazemore 822 Whitmore Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.71				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Infected Amputation Stump DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Arteriosclerosis peripheral was underlying disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes Mellitus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-1-72 to 3-10-72 that (I) (we) last saw the deceased alive on 3-10-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Gerald Crowley M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-10-72	
23C. PHYSICIAN'S NAME (Type) GERALD CROWLEY				23D. ADDRESS NOTTER FUNERAL HOME 3035 W. NORTH AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-11-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 12 1972		25B. NAME OF REGISTRAR John E. Jones		25C. FUNERAL DIRECTOR NOTTER FUNERAL HOME 3035 W. NORTH AVE.			

Barial

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02522		REG. NO. 72 02522	
S-300 BIRTH NO. 1. NAME OF DECEASED (Type or Print) SCOTT, JAMES E.				2. DATE AND HOUR OF DEATH 3/9/72 1:55 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BOW SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1901 5. CITY OR TOWN MD 21223 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 212 N. CARRY ST			
5. SEX male 6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/16/31 9. AGE (In years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Fireman	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Fireman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Scott				14. MOTHER'S MAIDEN NAME Louise Franklin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. Korean		17. INFORMANT Mrs. Rosa E. Scott ADDRESS 410 Floyd Street Lynchburg, Virginia			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pulmonary embolus minutes DUE TO, OR AS A CONSEQUENCE OF: (main pulmonary artery) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Atherosclerotic Heart Disease yes				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2/5/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from March 1, 1972 to March 9, 1972 that (I) (we) last saw the deceased alive on March 9, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Mahmud Yungying M.D. DEGREE				23B. DATE SIGNED 3-9-72		23C. PHYSICIAN'S NAME (Type) MAHME YUNYONGYING M.D. DEGREE BSH.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-12-72		24C. NAME OF CEMETERY or CREMATORY Fairmont Church Cemetery Amherst Co.,		24D. LOCATION (City, town, or county) (State) Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR J. E. Taylor M.D.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.			

9215 SS

9215 SS

9215 SS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

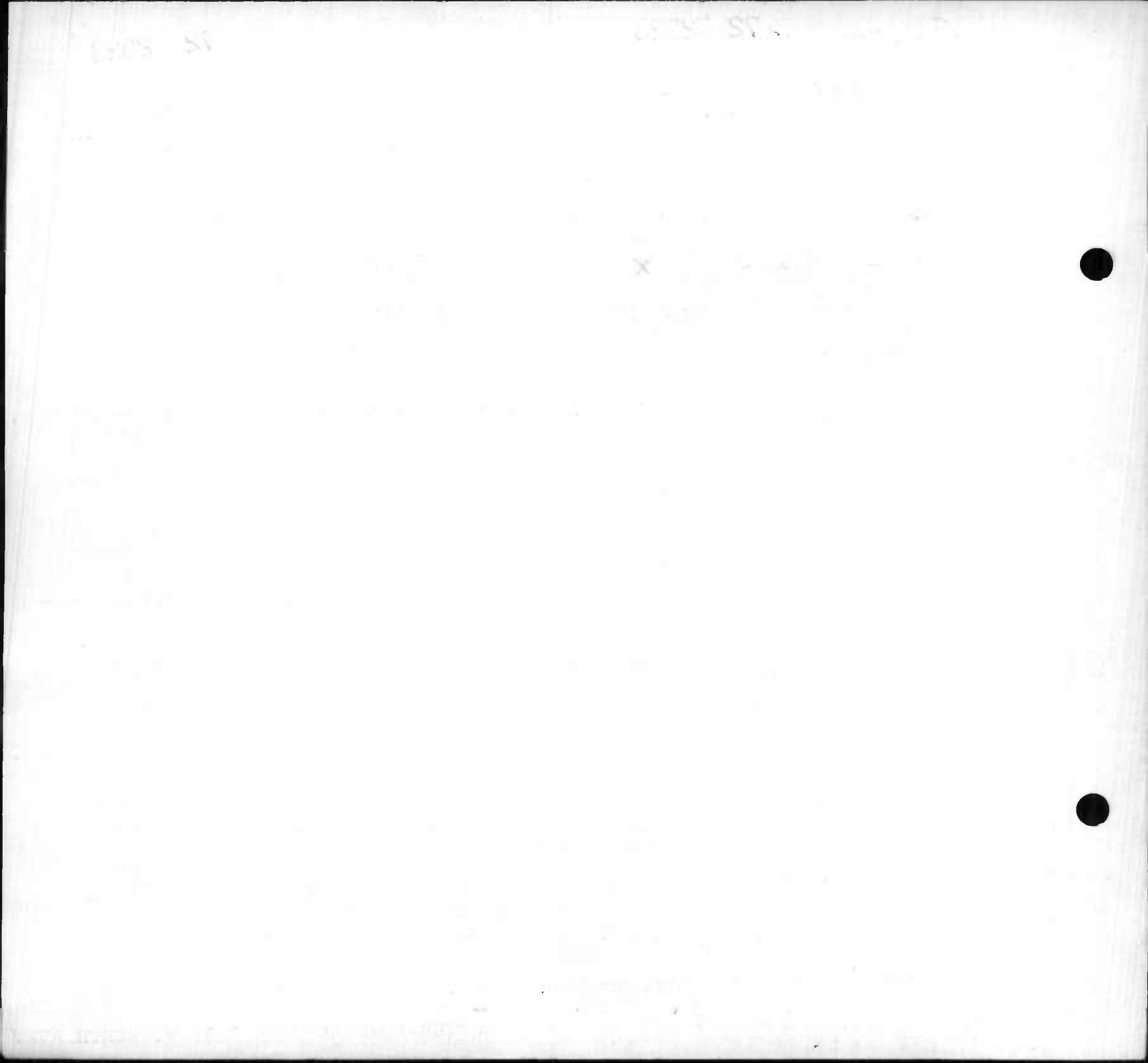
0-652

72 02523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02523

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN C. ORANGE		2. DATE AND HOUR OF DEATH 3/9/72 7:15p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2740		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE 42			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Black 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5/15/87		9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE MAKER			10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME GEORGE ORANGE		
14. MOTHER'S MAIDEN NAME LAURA ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-32-2024			17. INFORMANT Mr. J. Milton Orange 5910 Simmonds Ave,		
18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CV.A. Days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from 3/5 1972 to 3/9 1972 that (N) (we) last saw the deceased alive on 3/9 1972 and that (N) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. KERZNER MD			23B. DATE SIGNED 3/9/72		23C. PHYSICIAN'S NAME (Type) B. KERZNER
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-14-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park
24D. LOCATION Baltimore Co., Maryland			25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Michael Platzyk (Plotczyk)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72		Hour 5:35 a. M.	
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9/15/53		10. AGE (In years last birthday) 20		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bernard Plotczyk		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	
15. MOTHER'S MAIDEN NAME Czurywa		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Bernard Plotczyk		ADDRESS 2216 E. Portugal St.		21. AUTOPSY? (Yes or No)	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? 700 Black Patterson Ave 703	
22D. TIME OF INJURY (APPROX.) 3 10 72 6:32 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? SHOT BY UNKNOWN ASSAILANT	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/72	
24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) Dundalk Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 13 1972	
24F. NAME OF REGISTRAR		24G. FUNERAL DIRECTOR		24H. ADDRESS 401 S. Chester St.	

X

1505 51

1505 51

1505 51

1505 51

1505 51

1505 51

1505 51

1505 51

1505 51

1505 51

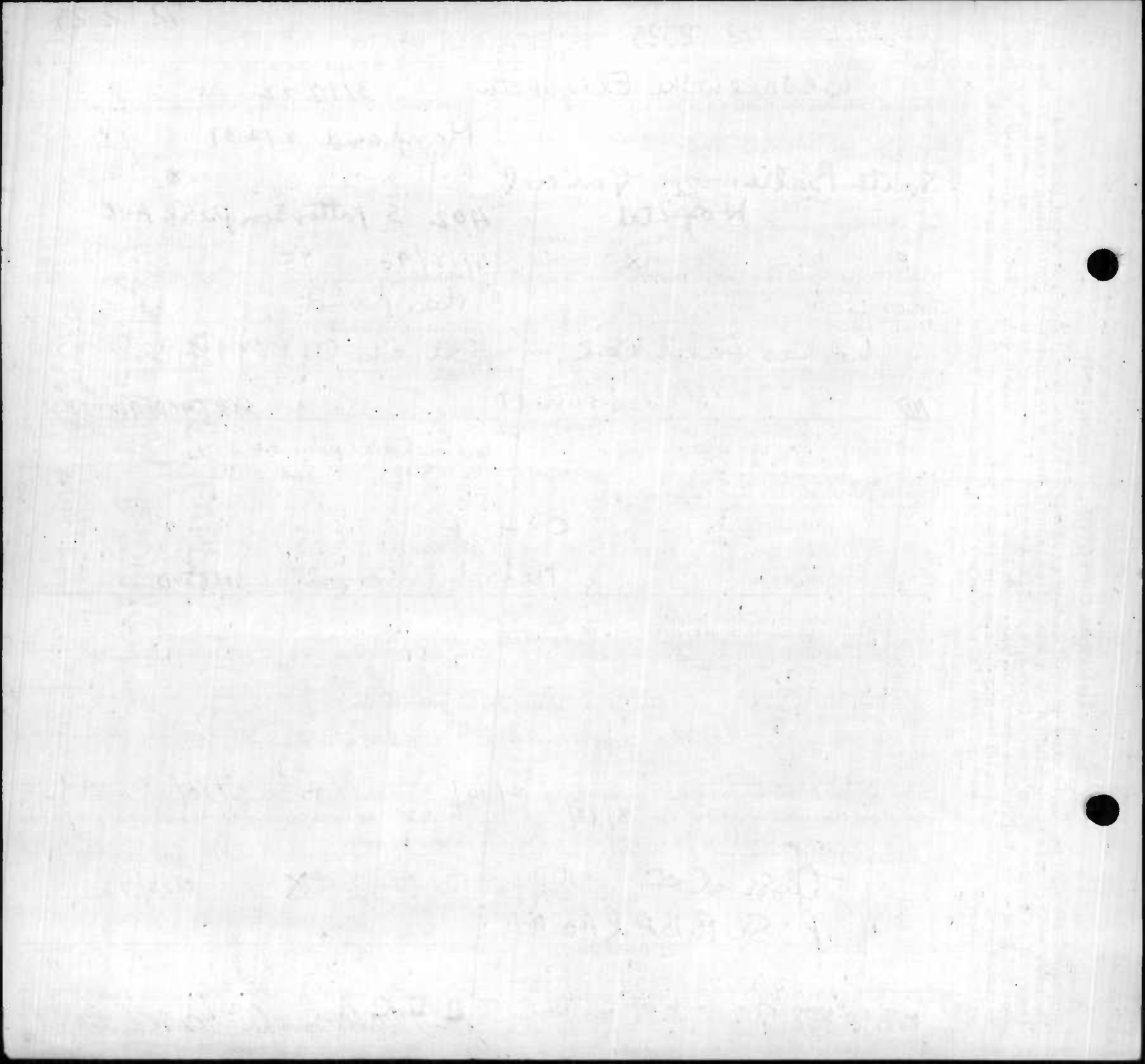
1505 51

1505 51

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02525		72 02525	
W-252		72 02525		72 02525	
BIRTH NO.		72 02525		REG. NO.	
1. NAME OF DECEASED (Type or Print) Wisniewski Elizabeth		2. DATE AND HOUR OF DEATH 3/10/72 at 4:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		A. STATE Maryland		B. COUNTY 21231 105	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 402 S. Patterson Park Ave					
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/96	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Fabickak		14. MOTHER'S MAIDEN NAME Elizabetha Proykylaska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-54-6324-T		17. INFORMANT Mrs. Stella Kozak	
				ADDRESS 5436 GARDENWOOD RD	
18. 394.91		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Intractable pulm oedema (A) IMMEDIATE CAUSE 2 Super added pneumonia DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) C.H.F DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Mitral incompetence CHAFD			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/14/1972 to 3/10/1972 , that (I) (we) last saw the deceased alive on 3/10/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) P. SUBBARAO M.D.				23D. ADDRESS [Address]	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3/14/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR [Name]		25C. FUNERAL DIRECTOR [Name]	
				ADDRESS 4015 Chester St	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02526

72 02526

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>(Odell) Brice, Odelle W.</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>3</u> Day <u>10</u> Year <u>72</u> Hour <u></u> M. <u></u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>		3. DATE PRONOUNCED DEAD Month <u>3</u> Day <u>10</u> Year <u>72</u> Hour <u>4:50</u> p. M. <u></u>	
6. SEX <u>male</u>		7. RACE <u>Negro</u>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>	
9. DATE OF BIRTH <u>Nov. 13, 1925</u>		10. AGE (In years last birthday) <u>46</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>908</u>	
15. MOTHER'S MAIDEN NAME		E. STREET AND NUMBER <u>518 E. 21st Street</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>		17. SOCIAL SECURITY NO. <u>248-42-3037</u>	
18. INFORMANT <u>Mozelle V. Brice</u>		ADDRESS <u>518 E. 21st Street</u>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Fatty metamorphosis of liver</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20. DATE OF OPERATION <u>57181</u>		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D. EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-16-72</u>	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <u>Winnsboro, S.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 19 1972</u>		25B. NAME OF REGISTRAR <u>John E. Jones, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Wm C March</u>		ADDRESS <u>928 E North Ave.</u>	

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

72 02527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02527

BIRTH NO. 66-09554

1. NAME OF DECEASED (Type or Print) Herman Davis Jr		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 3 9 72		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year 3 9 72		Hour 3:34 p.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2653				
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.
9. DATE OF BIRTH May 9, 1966		10. AGE (In years last birthday) 5 1/2		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 4406 Clareway
13. FATHER'S NAME Herman L. Davis Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
15. MOTHER'S MAIDEN NAME Delilah Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Herman L. Davis 4406 Clareway		
19. E814.17 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION 3-13-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3800 Sinclair La. (Balto. City)
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 3 9 72 3:20 p.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject pedestrian hit by car while crossing street.
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 3/10/72				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS 2653 March 928 E North Ave.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 02528

BIRTH NO. 72 02528

1. NAME OF DECEASED (Type or Print) CHARLES D. HAMILTON		2. DATE AND HOUR OF DEATH 3/10/72 4:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1205	
5. SEX Male 6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-18-106		9. AGE (In years last birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Seaman	
11. BIRTHPLACE (State or foreign country) Brusperk, Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vladimir Karel Zindle ?		14. MOTHER'S MAIDEN NAME Adolfina Hilla	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII ?		16. SOCIAL SECURITY NO. A 465-03-2940	
17. INFORMANT Mrs. Chas. D. Hamilton		ADDRESS 1800 N. Charles St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/9 19 72 to 3/10 19 72 that (1) (we) last saw the deceased alive on 3/9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George C. Samaras MD		23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) GEORGE C. SAMARAS MD		23D. ADDRESS MARYLAND GENERAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/72	
24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
25A. DATE REC'D. BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert E. Feltz MD	
25C. FUNERAL DIRECTOR STEWART & MOWEN CO.		ADDRESS 108 W. North Ave (1)	

[Faint, illegible handwriting throughout the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02529	
BIRTH NO. 72 02529		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES H. LIEBIG		2. DATE AND HOUR OF DEATH March 10, 1972 12:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3828 Hudson St. Baltimore, 21224, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2609	
5. SEX Male		6. RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-03.	
9. AGE (In years last birthday) 68		10. IF Under 1 Yr. Months Days IF Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse-Man		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Liebig		14. MOTHER'S MAIDEN NAME Mathilda Nolte	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-3840	
17. INFORMANT Mary M. Liebig		ADDRESS Same.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis		3hrs	
(B) Arteriosclerotic Vascular Disease DUE TO, OR AS A CONSEQUENCE OF:		?	
(C) _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Duodenal Ulcer		5yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 18, 1968 to March 10, 1972 , that (I) was last saw the deceased alive on March 6, 1972 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.			
23A. SIGNATURE Jason H. Gaskel, M.D.		23B. DATE SIGNED March 13, 1972	
23C. PHYSICIAN'S NAME (Type) JASON H. GASKEL		23D. ADDRESS 637 S. Conkling St., Balto., 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72.	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles S. Seiler		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.	

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

72 02530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02530

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (MARY R. MALASHUK) Mary Malashuk		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 10 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Balto. City Hospital		3. DATE PRONOUNCED DEAD Month 3 Day 10 Year 72 Hour 3:03 p.m.	
6. SEX female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Eastpoint	
9. DATE OF BIRTH Mar. 29, 1925		10. AGE (In years last birthday) 46 (46) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		14B. KIND OF BUSINESS OR INDUSTRY At Home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-10-3694	
18. INFORMANT Ellis J. Malashuk		ADDRESS Same.	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E814.17 MULTIPLE INJURIES		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			

20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? EASTERN AVE / NORTH PT BLVD	
22D. TIME OF INJURY (APPROX.) 3 10 72 1:30 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? PEDESTRIAN STRUCK BY AUTO	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
DATE SIGNED 3/11/72					

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-72.		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7725 Eastern Blvd., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Charles J. Gailer		ADDRESS 901 S. Conkling St. Balto., 21224, Md.	

FUNERAL DIRECTOR: IMPORTANT

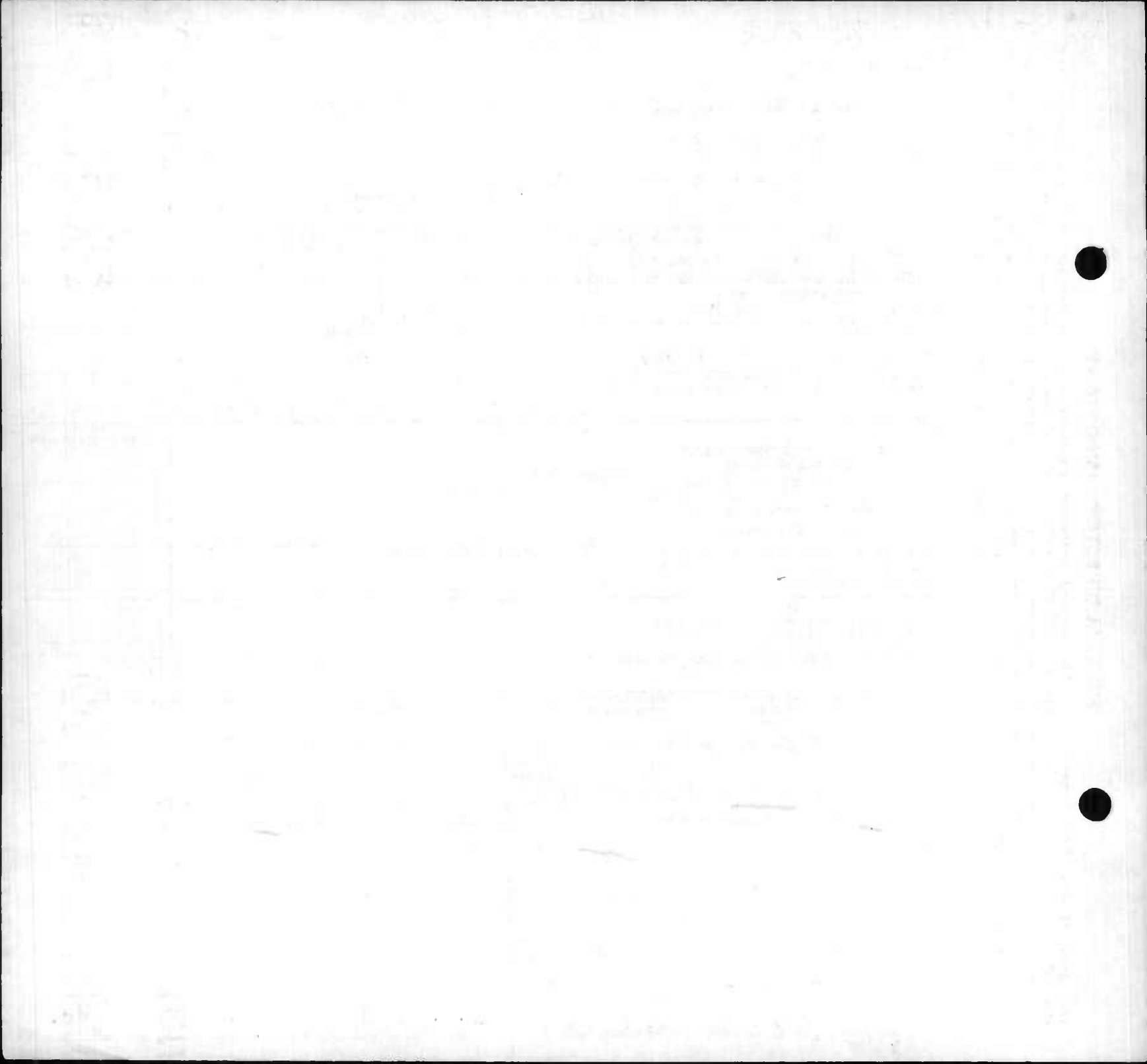
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">L5261</p> <p style="font-size: 24pt; margin: 0;">72 02531</p>		<p style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="margin: 0; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p style="margin: 0;">REG. NO. 72 02531</p>	
1. NAME OF DECEASED (Type or Print) LANGBARTNER BARBARA			2. DATE AND HOUR OF DEATH 12 Mar 72 4:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital. 100 N. Broadway Balto. MD. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY USA C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 513 S. Macon St. #21224.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-03-10	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Grimmer		10B. KIND OF BUSINESS OR INDUSTRY ESSKAY MEAT CO.	11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANDREW SCHWALB			14. MOTHER'S MAIDEN NAME Katherine Maher		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-28-9930	17. INFORMANT George Langbartner Husband ADDRESS 513 S. Macon St. BALTO., MD.		
18. 153.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Cardio Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: 1 month (B) Anemia Starvation due to DUE TO, OR AS A CONSEQUENCE OF: 1 year (C) Adeno Carcinoma sigmoid		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Metastasis in liver & internal organs 8 months					
19A. DATE OF OPERATION 07-12-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma sigmoid	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-2-72 19 to 3-12-72 19 that (I) (we) last saw the deceased alive on 11 Mar 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/12/72
23C. PHYSICIAN'S NAME (Type) S. P. GIRDHAR MD.			23D. ADDRESS Church Home & Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-15-72	24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., BALTO., CO., MD.		
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972	25B. NAME OF REGISTRAR Robert E. Fisher, MD.		25C. FUNERAL DIRECTOR Charles S. Fisher ADDRESS 901 S. CONRLING ST. BALTO., MD.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02532		BALTIMORE CITY HEALTH DEPARTMENT		72 02532	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARQUETTE, LEONORA K.		3-11-72 1:55 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hosp		Md BALTIMORE			
48		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		9025 Purring Park Rd			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Oys: Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-01-90	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED - SELF EMPLOYED		ORGANIST TEACHER		Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
ALBERT F. KOKE		CATHERINE LANG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		214-24-7486		1430 JOHN ST. MRS. BETTY FOOTE 21217	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Myocardial Infarction 13 hours			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Atrial fibrillation, 2y ASCVD			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/11 1972 to 3/11 1972 that (I) (we) last saw the deceased alive on 3/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. GAKUBA				3-11-72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
C. GAKUBA		Maryland General Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3-14-72		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 13 1972		R. E. Feltz, Jr.		F. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02533		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 02533	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		OSCAR ^{Lee} DANIELS		MARCH 10, 1972 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		561	
CHURCH HOME AND HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35		E. STREET AND NUMBER 1035 ORLEANS ST. APT 2D.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-16-23	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DELIVERY MAN.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State, or foreign country) GREENVILLE, N. C.	
13. FATHER'S NAME IZEL DANIELS		14. MOTHER'S MAIDEN NAME FANNY MOORE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-2966		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE SEPTICEMIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: (B) PERITONITIS PARALYTIC ILEUS, PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC ALCOHOLISM CIRRHOSIS OF THE LIVER OSTEOARTHRITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Hrs. 48 Hrs. UNKNOWN. UNKNOWN UNKNOWN	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inotify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from MARCH 8 1972 to MARCH 10 1972 that (H) (we) last saw the deceased alive on MARCH 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rustum. Irani		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-10-1972	
23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI		M.D. DEGREE 23D. ADDRESS CHURCH HOME AND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 13 1972		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR Randolph J. Collick		24H. ADDRESS 2431 E. Oliver St.			

88-5-33

88-5-33

88-5-33

88-5-33

88

88-5-33

88

88

88-5-33

88-5-33

88-5-33

88-5-33

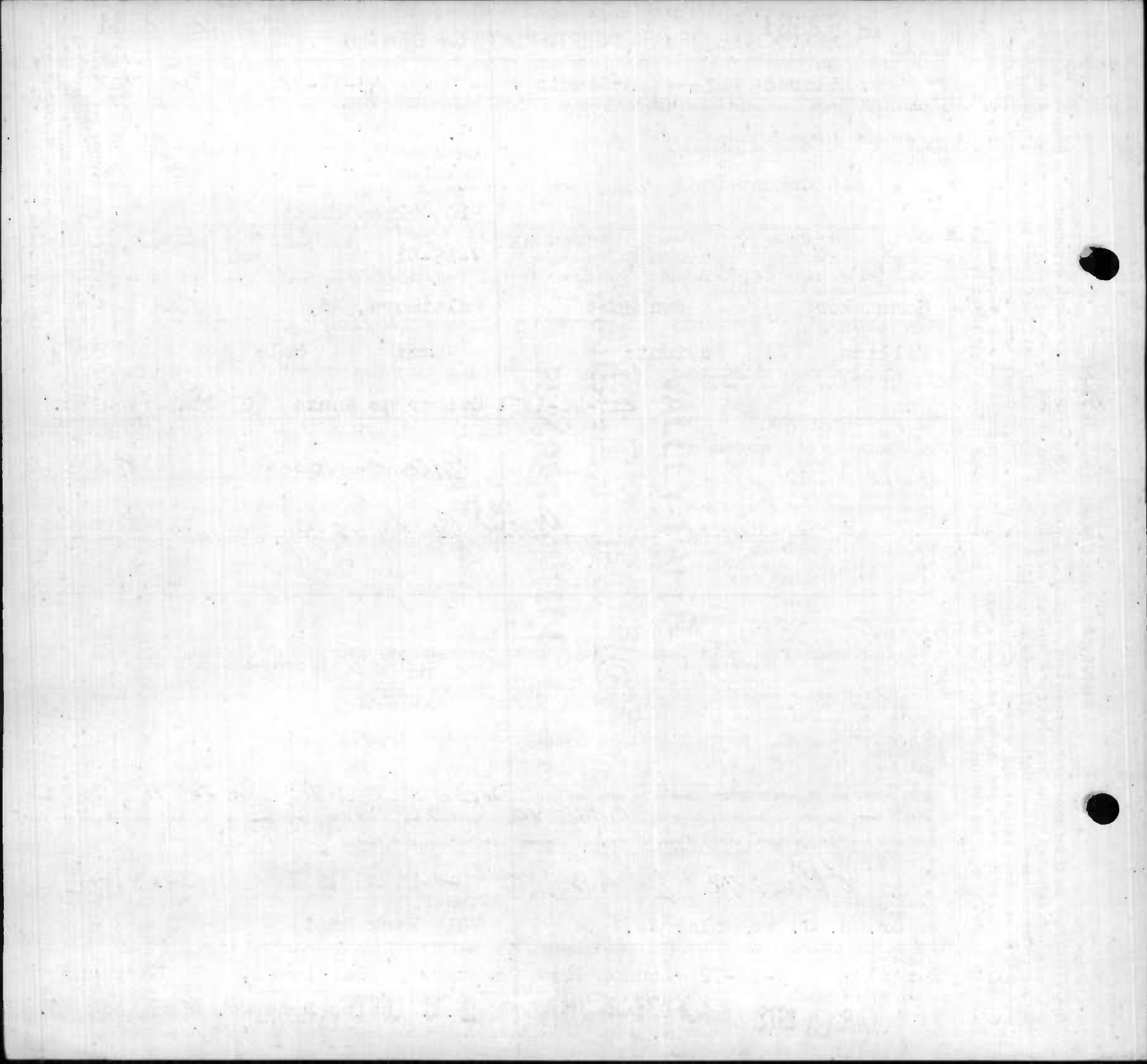
88

88-5-33

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02534	
72 02534		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mildred Hale McGinnis		2. DATE AND HOUR OF DEATH 3-11-72 7 ⁴⁵ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		2778	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 510 Orkney Road		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 510 Orkney Road					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-91	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William J. McGinnis		14. MOTHER'S MAIDEN NAME Emma Hale			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-46-1751		17. INFORMANT Catherine Konze 403 Dumbarton Rd.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMATOSIS</u> (B) <u>Problems Ca Lung</u> - (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 mos</u> <u>12 mos</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 5</u> 19 <u>71</u> to <u>MAR 11</u> 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>MAR 10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. S. J. Venable, Jr.</u>		23B. DATE SIGNED 3-13-72		23C. PHYSICIAN'S NAME (Type) Dr. S. J. Venable, Jr.	
23D. ADDRESS 7215 York Road		23E. ADDRESS 7215 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



72 02535

BALTIMORE CITY HEALTH DEPARTMENT

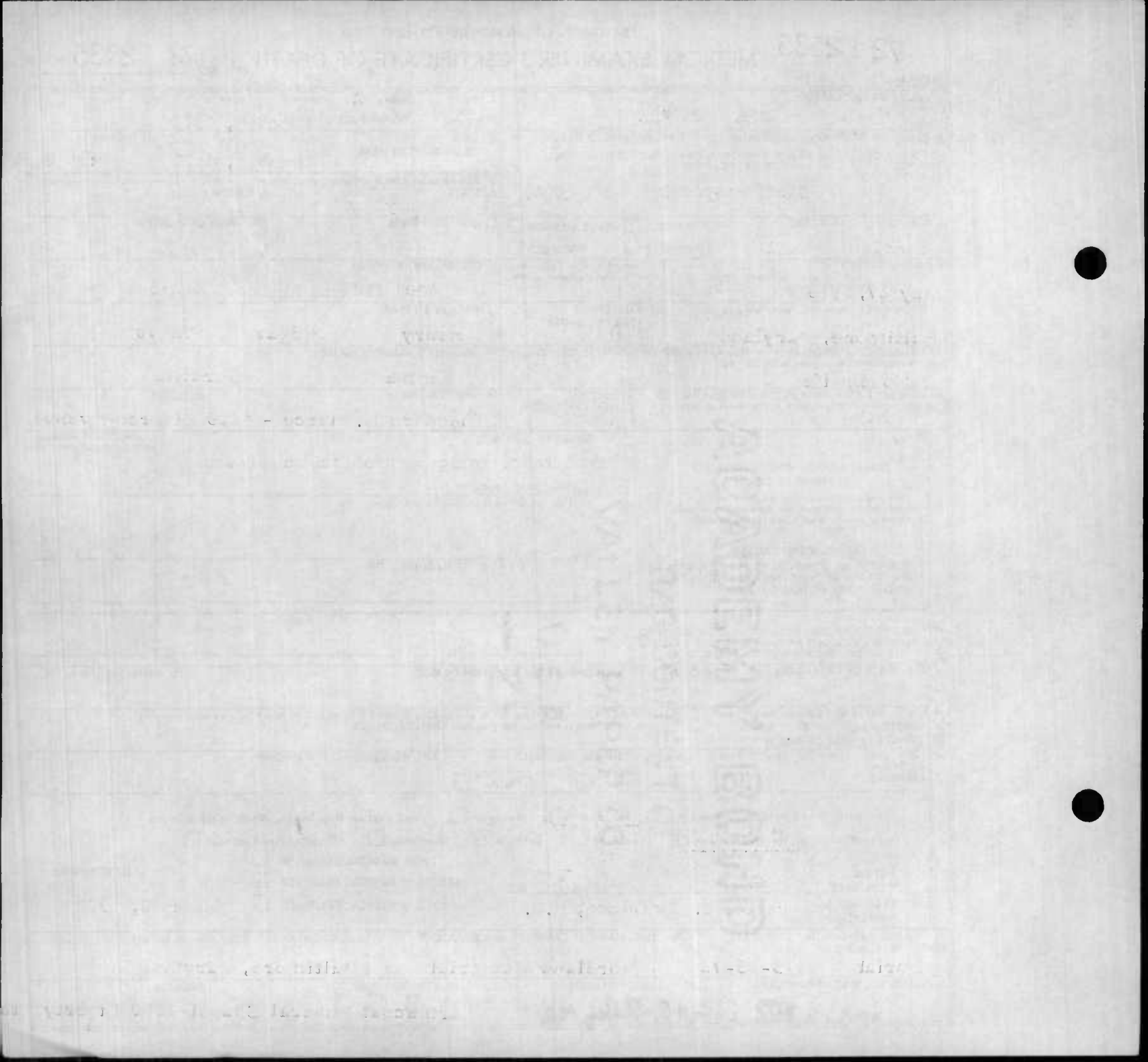
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02535

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ERMA PIERCE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> March 8, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1972 9:10 P M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 27, 1916		10. AGE (In years lost birth day) 55	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Edgar Flaggs		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2841	
15. MOTHER'S MAIDEN NAME Emma Gerstile		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. NO		18. INFORMANT ADDRESS Theodore L. Pierce - 4205 Elderon Avenue	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: March 9, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Armstrong Funeral Chapel		ADDRESS 4600 Liberty Hts	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02536

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02536

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Annie May Franklin

2. DATE AND HOUR OF DEATH

March 11, 1972

1 12.15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Anderson Nursing Home

3604 Mohawk Avenue, Balto, Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5219 St. Charles Avenue, Balto. 21215

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3/8/97

9. AGE (In years
last birthday)

75 yrs.

11. Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sales Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Goodwill Industries

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Benjamin Franklin

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-18-3557

17. INFORMANT

ADDRESS

Mrs. Clarence Huff, 1569 Williams Avenue

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(1) Hypertensive Heart Disease

5 yrs.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Phlebotomy

7 yrs.

(C) DUE TO, OR AS A CONSEQUENCE OF:

Chronic Osteoarthritis

5 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Obesity

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 29 1971 to March 11 1972
that (I) (we) lost saw the deceased alive on Jan 31 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Earl L. Chambers

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

3/13/72

23C. PHYSICIAN'S
NAME (Type)

Dr. Earl Chambers

23D. ADDRESS

100 West Cold Spring Lane, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/15/72

24C. NAME OF CEMETERY or CREMATORY

Sherwood Church Cem.

24D. LOCATION

(City, town, or county)

Cockeysville, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Arncost Funeral Chapel 4600 Lib. Hts.

at a distance

at a distance

at a distance

at a distance

at a distance

at a distance

at a distance

at a distance

at a distance

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02537

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alberta Davis		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72 Hour 12:25 p.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-25-09		10. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) Crawfordville, Ga.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Rhodes		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Hattie Collins		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N/A	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Bernice Lucas	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of abdomen ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1921 W. Balto. Street	
22D. TIME OF INJURY (APPROX.) 3 11 72 1:42 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject shot by unknown assailant		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 19 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton E. Dyett F. H.		ADDRESS 1701 Laurens St.	

1998

D-120

72 02538 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02538

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward Davis				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital				3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72 Hour 2:45 a.m.	
6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-11-1931		10. AGE (In years last birthday) 41		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1901	
11. BIRTHPLACE (State or foreign country) Norwood, Georgia				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				15. MOTHER'S MAIDEN NAME Alberta Rhodes	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 217-34-8806	
18. INFORMANT Eunice Davis				ADDRESS 110 N. Mount Street	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No)
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1921 W. Baltimore St - 2003	
22D. TIME OF INJURY (APPROX.) 3 11 72 142A		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) DATE SIGNED 3/11/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972			
25B. NAME OF REGISTRAR Morton S. Dyett		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens St.			

N875.1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02539

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAJOR ALONZO BRACEY				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1008 W. Lafayette Avenue				3. DATE PRONOUNCED DEAD March 8, 1972 1:00 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY 43							
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Fort Belvoir		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 10-29-1935		10. AGE (In years lost birthday) 36		E. STREET AND NUMBER ?			
11. BIRTHPLACE (State or foreign country) Bennettsville, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Otis Bracey			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY U. S. Army		15. MOTHER'S MAIDEN NAME Inez Bracey			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Present		17. SOCIAL SECURITY NO. 212-32-4183		18. INFORMANT Mrs. Inez Bracey		ADDRESS 4736 Wakefield Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1008 W. Lafayette Avenue 1601			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-8-72 A.M. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/8/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME of CEMETERY or CREMATORY Arlinton National Cemetery		24D. LOCATION (City, town, or county) (State) Arlinton, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 13 1972		25B. NAME OF REGISTRAR 3644 302 23 0 0 0		25C. FUNERAL DIRECTOR Morison Dye		ADDRESS Laurens Street Funeral Homes, Inc. 1701	

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-120		72 02540		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02540	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JULIA CATHERINE LOVAS					
2. DATE AND HOUR OF DEATH March 9 1972				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD JOHNS HOPKINS HOSPITAL 601 N. BROADWAY					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Prince George's				5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
C. CITY OR TOWN CHEVERLY				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
E. STREET AND NUMBER 2318 BELLEVIEW AVENUE				8. DATE OF BIRTH 12-15-08 9. AGE (In years last birthday) 63					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10B. KIND OF BUSINESS OR INDUSTRY Nat. Security agency				11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME THOMAS LOVAS					
14. MOTHER'S MAIDEN NAME MARY BANGO				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					
16. SOCIAL SECURITY NO. 235-34-7524				17. INFORMANT Pauline Leedy ADDRESS Hyattsville, Md.					
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) Cardiovascular arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 20 to increased intracranial pressure & astrocytoma of brain # 3 months				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). aspiration pneumonia									
19A. DATE OF OPERATION March 1/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Left hemiplegic brain				20A. AUTOPSY (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) home					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) March 9 1972				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
21F. HOW DID INJURY OCCUR? fall				22. I certify that (this hospital) attended the deceased from Feb. 28 1972 to March 9 1972 that (we) last saw the deceased alive on March 9 1972 and that (our) opinion death occurred on the date and hour and from the causes stated above (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Sarkarati F7782 MD				23B. DATE SIGNED 3/9/72				23C. PHYSICIAN'S NAME (Type) MEHDI SARKARATI MD	
23D. ADDRESS Johns Hopkins Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE Mar 13, 1972				24C. NAME of CEMETERY or CREMATOR Gate of Heaven				24D. LOCATION (City, town, or county) (State) Wheaton Montgomery Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 11 1972				25B. NAME OF REGISTRAR Charles J. ...				25C. FUNERAL DIRECTOR E. Gasch's Sons ADDRESS Hyattsville, Md.	

Central American
- 1930 E. American
with capital of Spain

republican government

March 1932 - 1933

March 1932 - 1933

March 1932 - 1933

BALTIMORE CITY HEALTH DEPARTMENT				72 02541			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 72 02541			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Robert Warren Sadler				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 20 Year 72 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				3. DATE PRONOUNCED DEAD Month 1 Day 20 Year 72 Hour 6:10 p.m.			
6. SEX male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH				10. AGE (In years last birthday) 48		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT				ADDRESS			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/21/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation				24B. DATE 3/9/72			
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21229			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972				25B. NAME OF REGISTRAR Morgue			
25C. FUNERAL DIRECTOR City of Baltimore				ADDRESS			

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

11/18/81

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02542	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. K-246 72 02542 </div>							
1. NAME OF DECEASED (Type or Print) Kochler - Elizabeth				2. DATE AND HOUR OF DEATH 3-9-72 2:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home 1400 John St - Balto. </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE MD </div> <div> B. COUNTY Balto </div> </div>			
5. SEX F				6. RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-18-87				9. AGE (In years last birthday) 85		10. UNDER 1 Yr. <input type="checkbox"/> 11. UNDER 24 Hrs. <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Marker - Grants Dept. Store				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME George J. Schafer			
14. MOTHER'S MAIDEN NAME Katherine Stein				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			
16. SOCIAL SECURITY NO. 220-18-4758				17. INFORMANT Randallstown, Md. 21133 Mrs. Irma Ruth 3704 Lamoine Road			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE Hypertensive Cerebral DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (C) Osteoarthritis generalized Asymptomatic kidney Left pleural </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years years 1 month </div> </div>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 3/10/72		23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHING	
23D. ADDRESS 2 E Read St Balto MD 21204				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3/13/1972				24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972				25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Loring Myers 8728 Liberty Rd Randallstown Md. 21125	

Spring 20

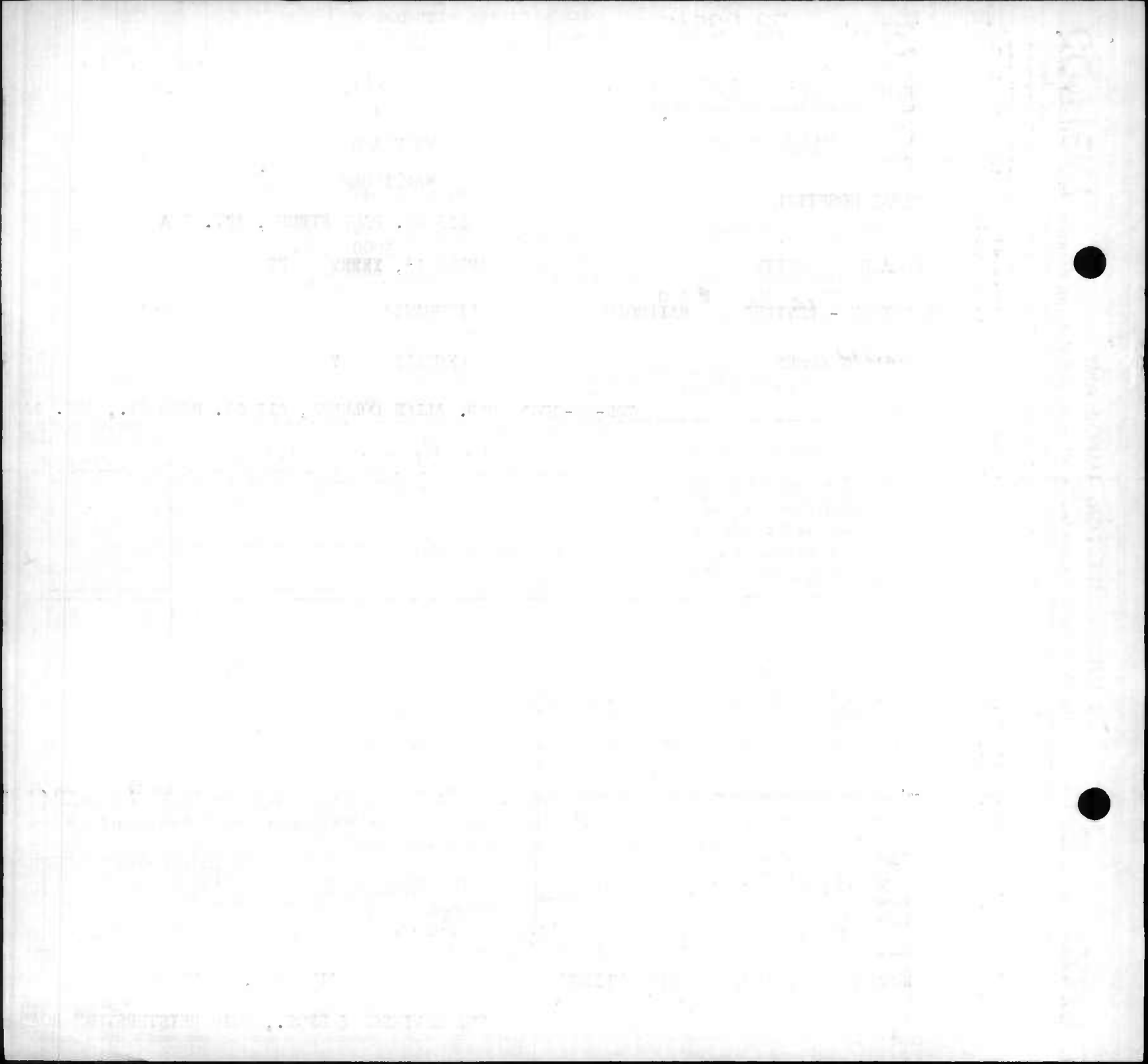
July



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

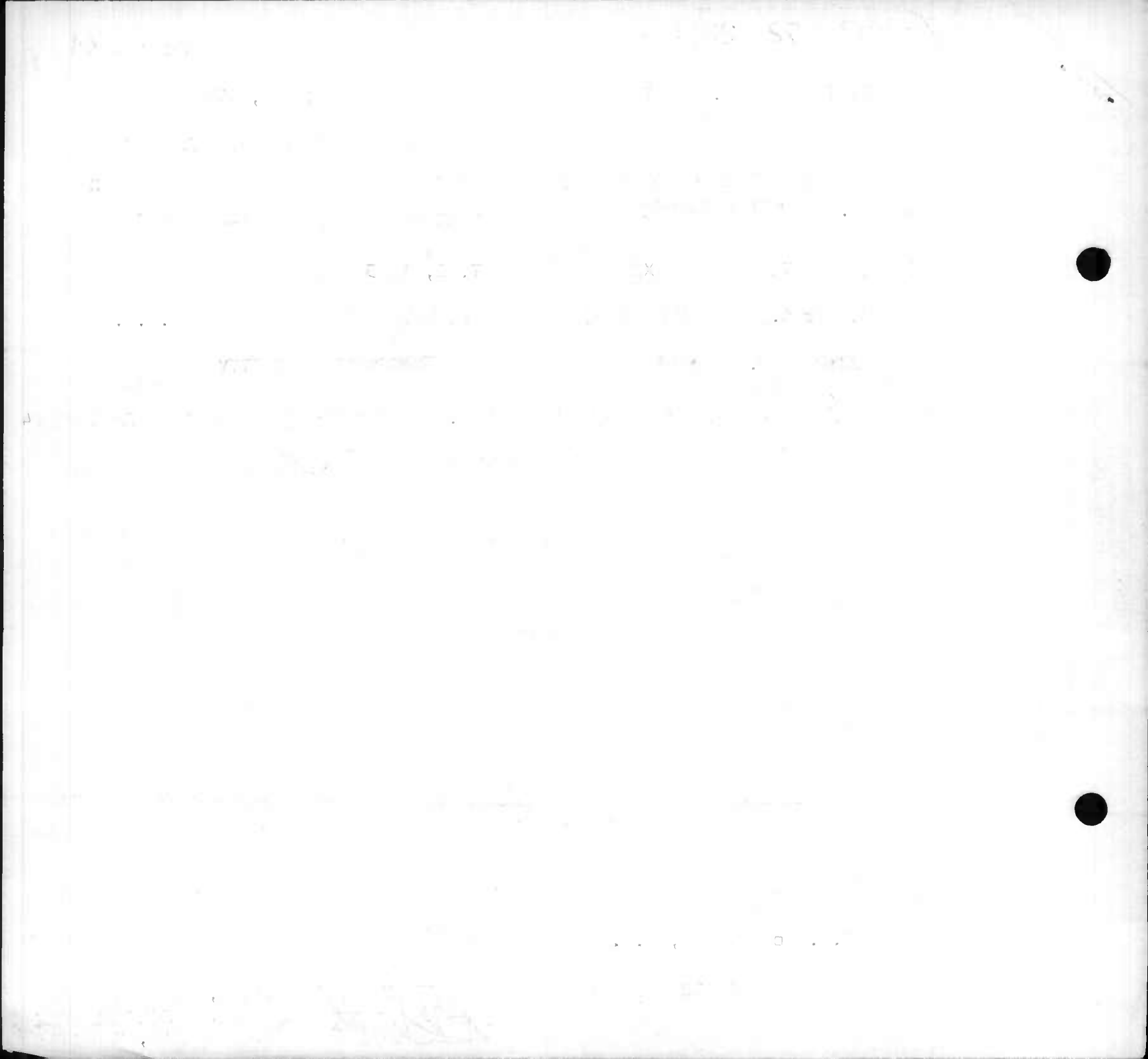
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
CERTIFICATE OF DEATH				72 02543	
C-500 72 02543		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) REBECCA BEATRICE COHEN		2. DATE AND HOUR OF DEATH 3/9/72 7:24 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1101			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		E. STREET AND NUMBER 813 ST. PAUL STREET, APT. 1 A	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1900 APRIL 14, 1900		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY - RETIRED		10B. KIND OF BUSINESS OR INDUSTRY B & O RAILROAD		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SOLOMON COHEN		14. MOTHER'S MAIDEN NAME CECELIA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 705-09-2701		17. INFORMANT MRS. ALICE COLEMAN, 813 ST. PAUL ST., APT. 1A	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH I Prox. Ac. Coronary Occlusion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Involuntarily medical examined		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to Mar 9 1972 that (I) (we) last saw the deceased alive on Mar 6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Bakal MD		23B. DATE SIGNED 3-9-72		23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL, MD	
23D. ADDRESS 3600 LOCHEARN DR 21207		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 3/10/72		24C. NAME OF CEMETERY OR CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR R. E. F. & S.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-200 72 02544		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02544	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BERTHA N. TOSH		2. DATE AND HOUR OF DEATH MARCH 11, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL		M.	
FULL NAME OF HOSPITAL OR INSTITUTION HOUSE IN THE PINES NURSING HOME 2528 W. BELVEDERE AVENUE		C. CITY OR TOWN PASADENA		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 1, 1883		9. AGE (in years last birthday) 88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER (ret.)		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME JOHN S. HOON		14. MOTHER'S MAIDEN NAME MARGARET BEATTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS. DOROTHY GEORGE (daughter) SAME AS #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the uterus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Shingles mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 20 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). none					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 2 19 60 to March 11 19 72 that (I) (we) last saw the deceased alive on March 11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R.M. McLaughlin		23B. DATE SIGNED March 11, 1972		23C. PHYSICIAN'S NAME (Type) R.M. McLAUGHLIN, M.D.	
23D. ADDRESS 3708 Mountain Road, Pasadena, Md. 21122					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MARCH 15/72		24C. NAME OF CEMETERY or CREMATORY LIGONIER VALLEY CEMETERY	
24D. LOCATION (City, town, or county) (State) LIGONIER, PENNSYLVANIA		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972			
25B. NAME OF REGISTRAR Robert E. Jarber, M.D.		25C. FUNERAL DIRECTOR R. K. Jarber			
25D. ADDRESS SINGLETON FUNERAL HOME		25E. ADDRESS GLEN BURNIE, MARYLAND			

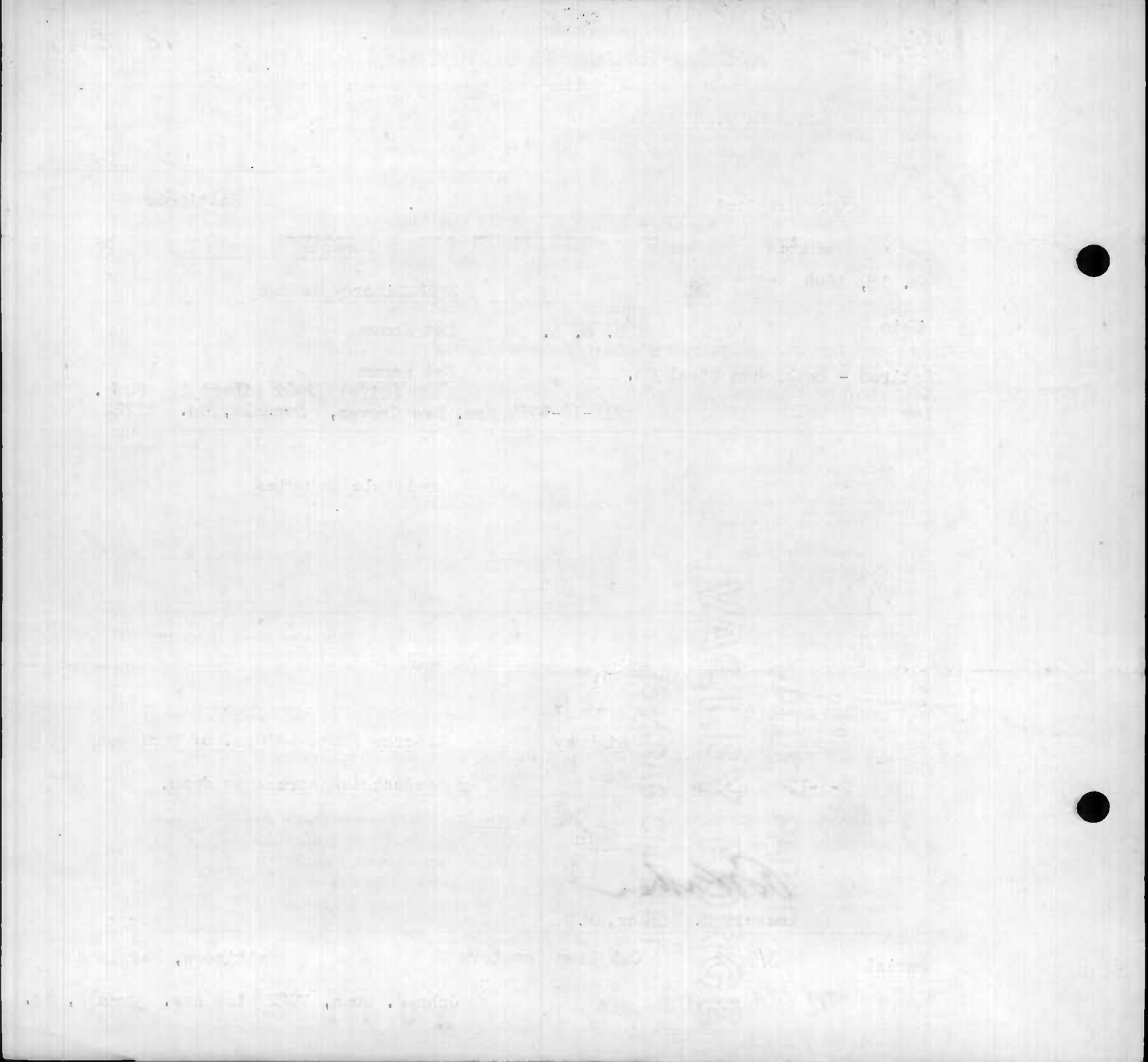


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

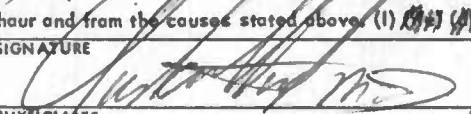
REG. NO.

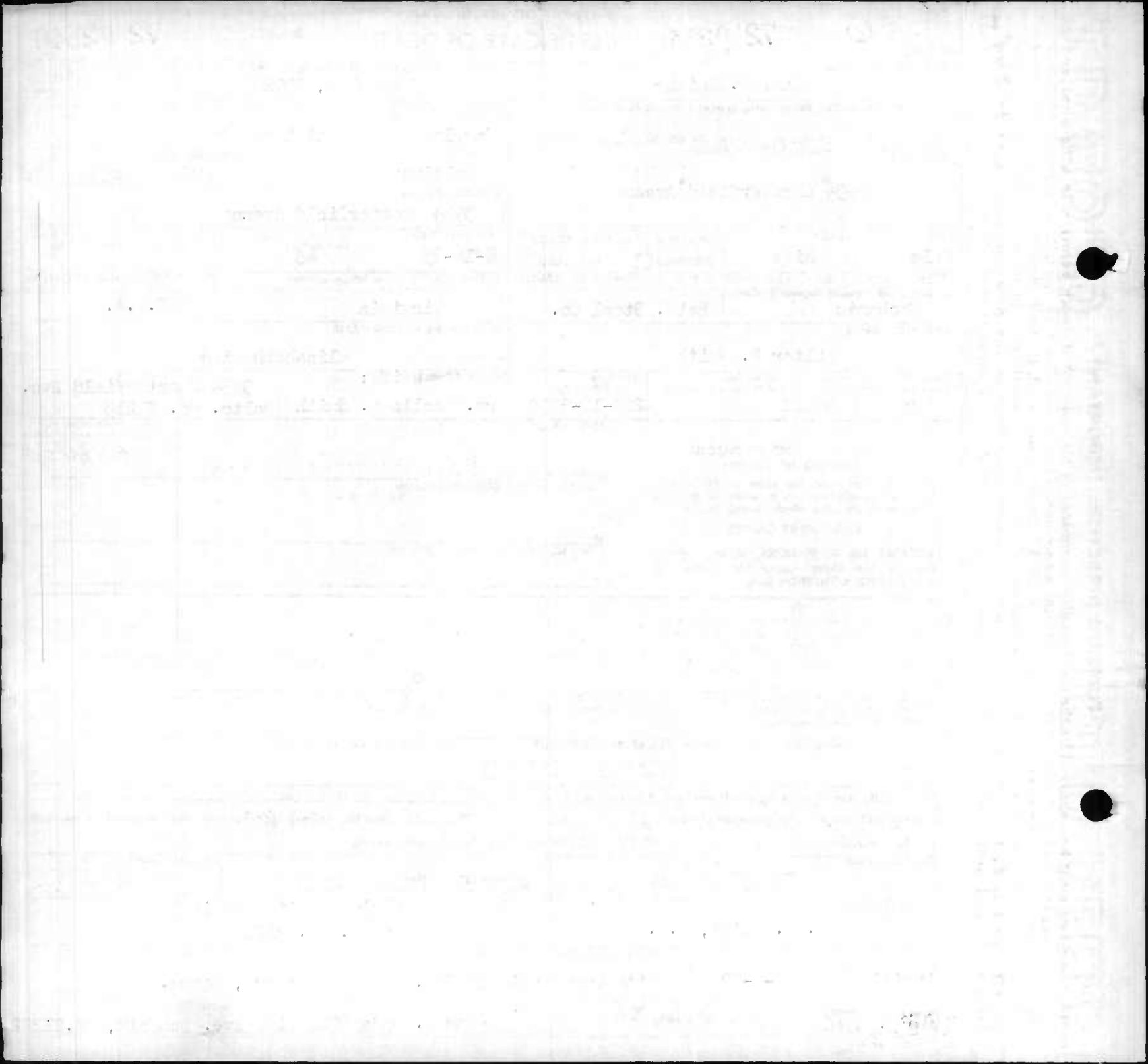
1. NAME OF DECEASED (Type or Print) CHALMER M. GROVES				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 5 1972 1:45 a M			
6. SEX male				7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Feb. 18, 1894				10. AGE (In years lost birthday) 78		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF U. S. A.				13. FATHER'S NAME Not Known		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bethlehem Steel Co.	
15. MOTHER'S MAIDEN NAME Not Known				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) yes WWI		17. SOCIAL SECURITY NO. 216-10-4764	
18. INFORMANT (Wife) 2902 Liberty Pkwy. Mrs. Mae Groves, Dundalk, Md. 21222				19. CAUSE OF DEATH E-81417 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Liberty Pkwy. 48' so. of Dunningway			
22D. TIME OF INJURY (APPROX.) 3-5-72 6:55 p m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Pedestrian struck by auto.				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 3-6-72				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3/9/72				24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery			
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972			
25B. NAME OF REGISTRAR John J. Duda				25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. _____	
BIRTH NO. S-530		72 02546	
BIRTH NO. 72 02546		72 02546	
1. NAME OF DECEASED (Type or Print) Carl W. Smith		2. DATE AND HOUR OF DEATH March 6, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3934 Chesterfield Avenue IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3934 Chesterfield Avenue	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-25
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	9. AGE (In years (last birthday)) 46
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter P. Smith		14. MOTHER'S MAIDEN NAME Elizabeth Ring	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 220-12-3930	
17. INFORMANT Wife: Mrs. Luella M. Smith		ADDRESS 3934 Chesterfield Ave. Balto. Md. 21213	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ACUTE MYOCARDIAL INFARCTION		6 mos	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Oct 1 1971 to present 19 72 that (2) (we) last saw the deceased alive on 8 FEB 19 72 and that (3) (my) opinion death occurred on the date and hour and from the causes stated above (1) (2) (3) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 7 MARCH 72	
23C. PHYSICIAN'S NAME (Type) G. C. Voigt, M.D.		23D. ADDRESS Baltimore City Hospital Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-9-72	
24C. NAME of CEMETERY or CREMATORY Gettysburg National Cem.		24D. LOCATION (City, town, or county) (State) Gettysburg, Penna.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02547		CERTIFICATE OF DEATH		X		REG. NO. 72 02547	
1. NAME OF DECEASED (Type or Print) <u>Hilda A. Redmond</u>		2. DATE AND HOUR OF DEATH <u>4:10 P 11 March 72</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Baltimore General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4308 Cortez Road</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7.10.1910</u>		9. AGE (In years last birthday) <u>62</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217 09 9345</u>		17. INFORMANT <u>Robert R. Redmond Sr.</u> ADDRESS <u>4308 Cortez Road</u>					
18. <u>1830 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Massive pulmonary embolism RT.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pleural metastases</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Ovarian carcinoma</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>weeks</u> <u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>11 Mar 72</u> to <u>11 Mar 72</u> that (I) (we) last saw the deceased alive on <u>11 Mar 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>John R. Culbert Jr. MD.</u>				23B. DATE SIGNED <u>12 Mar 72</u>		23C. PHYSICIAN'S NAME (Type) <u>John R. Culbert Jr. MD.</u>			
23D. ADDRESS <u>McGully Funeral Home 237 Patapsco Ave</u>		23E. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>John R. Culbert Jr. MD.</u>		25C. FUNERAL DIRECTOR <u>McGully Funeral Home</u>		25D. ADDRESS <u>237 Patapsco Ave</u>			

8-212

75-5245

75-5245

101164 1000000

101164

101164

101164 1000000 101164 1000000

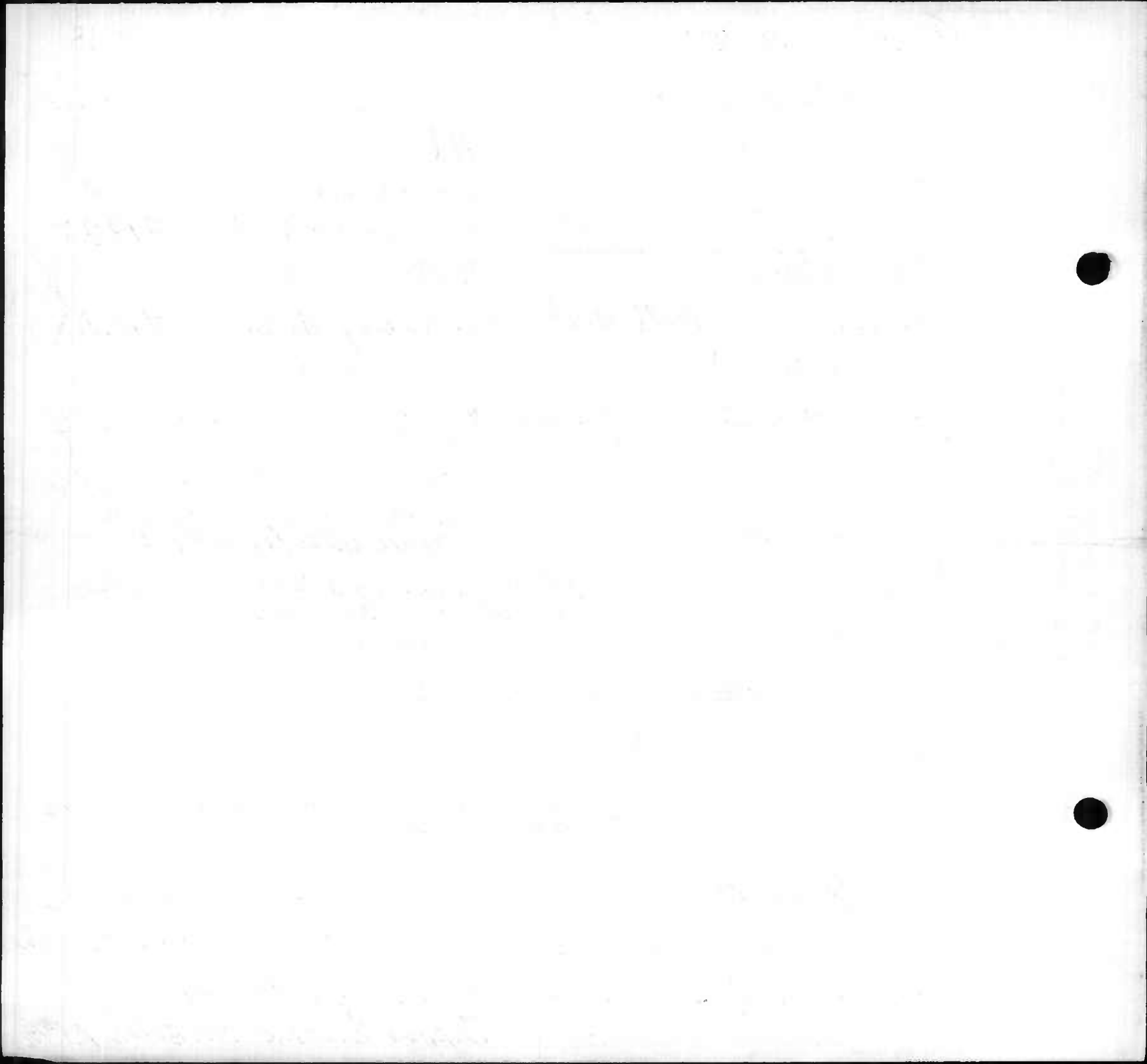
101164 1000000 101164 1000000

101164 1000000 101164 1000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-260 72 02548		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 02548	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wilbur H. Oxier</i>		2. DATE AND HOUR OF DEATH <i>10 March 1972 5:25 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>		5. CITY OR TOWN <i>Lansdowne</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>440 Burbank CT 21227</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/11/20</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>labor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i>		11. BIRTHPLACE (State or foreign country) <i>Clarksburg W. Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>(unknown)</i>		14. MOTHER'S MAIDEN NAME <i>(unknown)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW II</i>		16. SOCIAL SECURITY NO. <i>219-16-3641</i>		17. INFORMANT <i>Mary Ann Oxier 440 Burbank CT</i>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Rheumatic Heart disease</i> <i>mitral stenosis & insufficiency</i>		<i>20 years</i>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Aortic insufficiency</i>			
		(C) <i>Mitral valve Replacement</i>		<i>2 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<i>Postoperative bleeding -</i> <i>Heart failure -</i>			
19A. DATE OF OPERATION <i>8 March 72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>mitral insufficiency</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 72</i> to <i>March 10 19 72</i>		that (I) (we) last saw the deceased alive on <i>March 10 19 72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>V. Hernandez</i>		23B. DATE SIGNED <i>March 10/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Victor Hernandez</i>	
23D. ADDRESS <i>University of Maryland Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>cremation</i>		24B. DATE <i>3/13/72</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Greenmount Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1972</i>	
25B. NAME OF REGISTRAR <i>J. E. Jones</i>		25C. FUNERAL DIRECTOR <i>Dippel Bros Inc</i>		ADDRESS <i>7110 Bole Rd. 21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

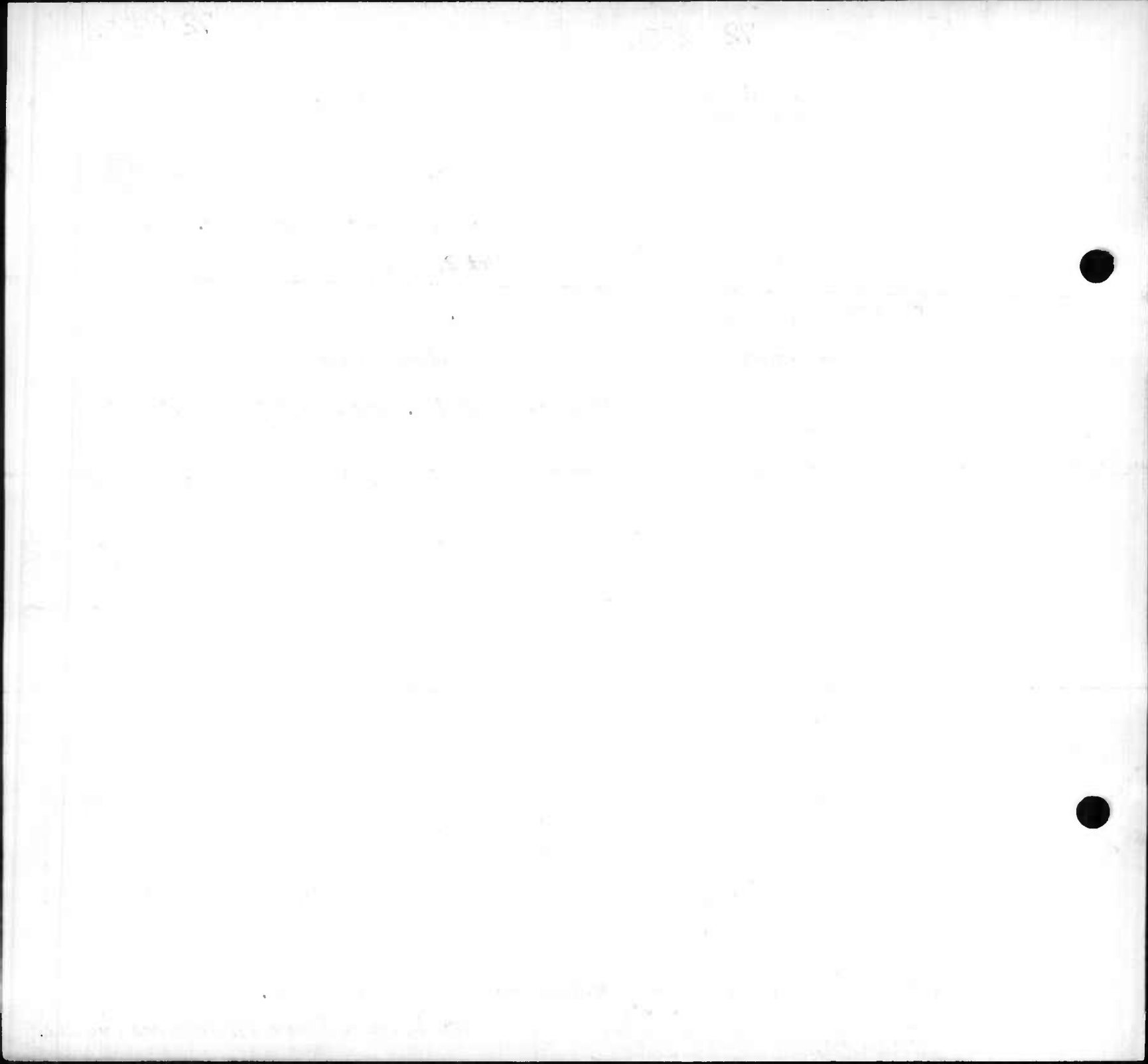
B-325		72 02549		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		72 02549	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>BATSON, ELEANORE</u>				2. DATE AND HOUR OF DEATH <u>3/8/72</u> <u>3:30</u> PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Anne Arundel Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>George Washington Nursing home</u> <u>607 Pennsylvania ave.</u> <u>90</u>						C. CITY OR TOWN <u>Annapolis</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Black</u>						7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-1904</u>	
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>						9B. KIND OF BUSINESS OR INDUSTRY		9C. AGE (In years last birthday) <u>70</u>	
10. FATHER'S NAME <u>Charles BATSON, Sr</u>						11. MOTHER'S MAIDEN NAME <u>ELLEN JENNINGS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>						14. SOCIAL SECURITY NO. <u>212-583959</u>		15. INFORMANT <u>Edna - Brother - 112 CLAY ST, ANNAPOLIS</u>	
16. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Stroke</u>						17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CVA</u>						19. DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>1969</u>									
21A. DATE OF OPERATION <u>0</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <u>4-18-1969</u> to <u>3-8-1972</u> that (1) (we) last saw the deceased alive on <u>3-8-1972</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Richard F. Tyson, M.D.</u>						23B. DATE SIGNED <u>3/8/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Richard Tyson, M.D.</u>						23D. ADDRESS <u>936 W. North ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-11-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Brewer Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Annapolis A.A.C.O MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>W. H. HICKS</u>		25C. FUNERAL DIRECTOR <u>C. E. HICKS</u> ADDRESS <u>1922 Forest Drive ANNAPOLIS, MD</u>					

09 109455 -P X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

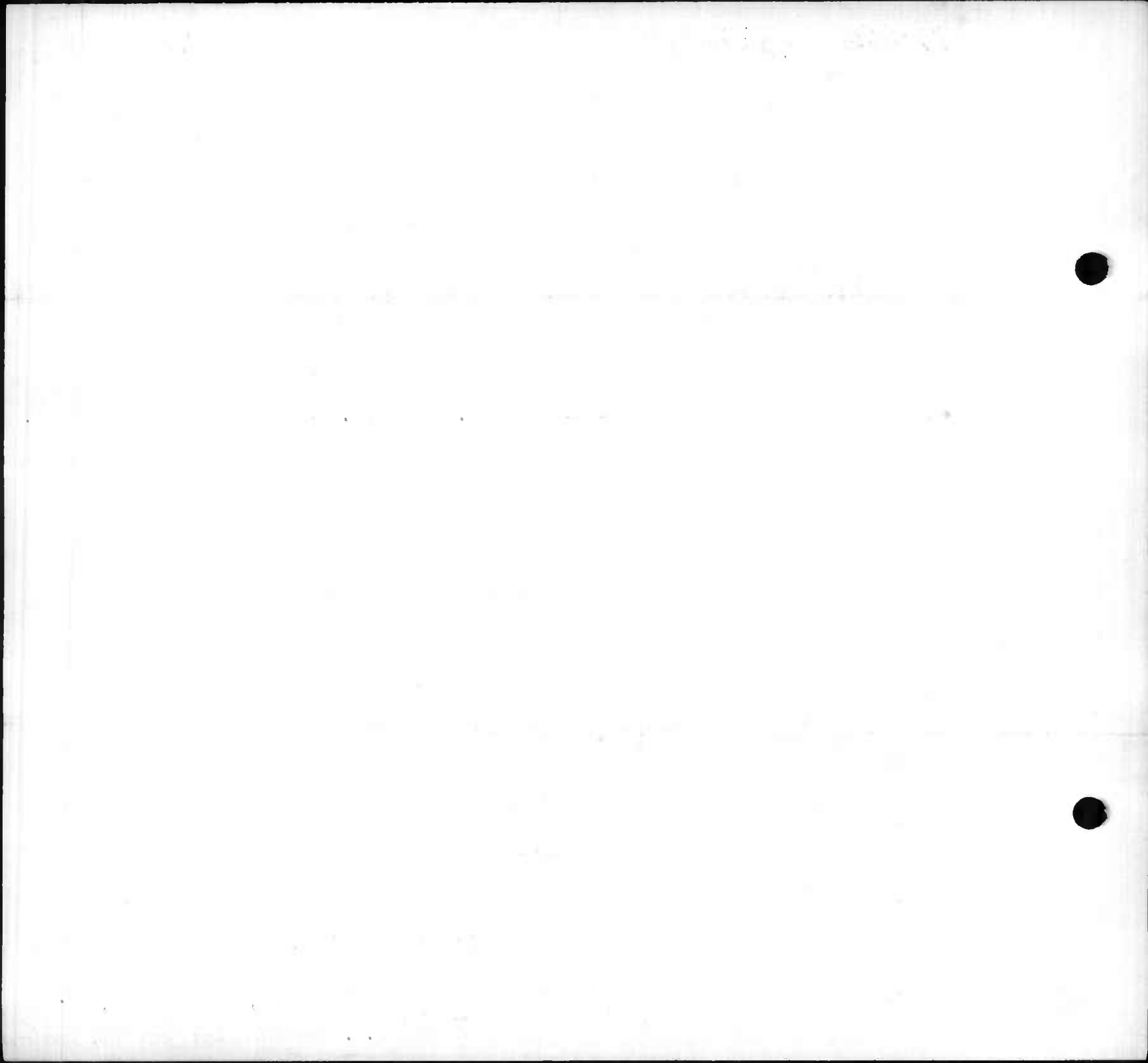
8-235		72 02550		BALTIMORE CITY HEALTH DEPARTMENT		72 02550	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Henry A Sexton</u>				2. DATE AND HOUR OF DEATH <u>March 10, 1972 12:30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2534</u>			
5. SEX <u>M</u>		6. RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 2, 1909</u>	
9. AGE (In years last birthday) <u>62</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Gordon Sexton</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Odham</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>240 03 6208</u>		17. INFORMANT <u>Bethel E. Sexton</u>	
18. <u>410.01</u> CAUSE OF DEATH				ADDRESS <u>3428 7th Street 21225</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarct</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>	
(B) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>HE</u> (this hospital) attended the deceased from <u>March 7</u> 19 <u>72</u> to <u>March 10</u> 19 <u>72</u> that <u>HE</u> (we) last saw the deceased alive on <u>March 10</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HE</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert P. Whitehead M.D.</u>				23B. DATE SIGNED <u>March 10, 1972</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/14/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Thorn Springs Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pulaski Va.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Whitehead, M.D.</u>		25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		ADDRESS <u>237 Patapsco Ave 21225</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 02551</u>	
BIRTH NO. <u>B-626</u> <u>72 02551</u>				2. DATE AND HOUR OF DEATH <u>March 11, 1972</u> <u>17:50</u> <u>A.M.</u>			
1. NAME OF DECEASED (Type or Print) <u>Berger, Thomas Raymond</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> <u>22 S. Greene St., Balto., Md.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel County</u> <u>5200</u>			
				C. CITY OR TOWN <u>Pasadena</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>Route 10 Box 108 A</u>			
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/18/13</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>asst. manager</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Distributing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Berger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Steinback</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-05-6242</u>		17. INFORMANT <u>Mrs. Kathryn R. Berger</u> <u>Rte 10 Box 108 A Md.</u>	
18. <u>204.11</u> CAUSE OF DEATH						ADDRESS <u>Pasadena</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Gram Negative Shock</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
				(B) <u>Peri-rectal abscess or Cellulitis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2 days?</u>	
				(C) <u>Chronic Lymphocytic Leukemia</u>		<u>1 year</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 19</u> <u>1972</u> to <u>March 11</u> <u>1972</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 11</u> <u>1972</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard A. Tomasulo M.D.</u>				23D. ADDRESS <u>University Hospital, Greene & Lombard Streets</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/14/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Anne Arundel, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>Blaise E. Jahn, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mc Cully F.H. Mountain & Tick Neck Rds, Pasadena</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>G-536 72 02552 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH REG. NO. 72 02552</p>	
BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Gundersen, Marie	
2. DATE AND HOUR OF DEATH 3-10-72 7:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Narbon View Nursing & Conv. Center	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY CALVERT 5400	
C. CITY OR TOWN Chesapeake Beach D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER	
5. SEX F	6. RACE W
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-20-80	
9. AGE (In years last birthday) 92	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10B. KIND OF BUSINESS OR INDUSTRY Un Known	
11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jorgen Gundersen	
14. MOTHER'S MAIDEN NAME Eline Sykertsen	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 212-56-0253	
17. INFORMANT Nursing Home Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: AS C. V. D. - Cardiac Decompensation C.B.S. - - Acute	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/12 1971 to 3/10 1972 , that (I) (we) last saw the deceased alive on 2/19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Joseph S. Blum	
23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM	
23D. ADDRESS 1115 N. CALVERT ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	
24B. DATE 3/11/72	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972	
25B. NAME OF REGISTRAR Robert E. Blum	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	

22 xix

xxxx

1984

XXXXXXXXXXXXX XOLWY

XXXXXXXXXXXXX

XXXXXXXXXXXXX WINE G. VERMONT

XXXXXXXXXXXXX

XXXXXXXXXXXXX

NO

XXXXXXXXXXXXX

XXXXXXXXXXXXX

XXXXXXXXXXXXX

XXXXXXXXXXXXX

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. P-100		BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 72 02553	
1. NAME OF DECEASED (Type or Print) Edward A. Popp		2. DATE AND HOUR OF DEATH 3/9/72 12 10 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2734	
5. SEX M		6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7/24/1893		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Balto. City Employee		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Popp		14. MOTHER'S MAIDEN NAME Elizabeth Schneemann	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-48-1035	
17. INFORMANT Mrs. Evelyn Rahley same		ADDRESS	
18. 1971-81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Decomposed Union Memorial Hospital Charged by Al B.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable drink / infection (B) Anteroseptic Gastrointestinal Distress (C) Chronic Anteroseptic	
19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/5/1971 to 3/9/1972 and that (I) (we) last saw the deceased alive on 1/5/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.			
23A. SIGNATURE Albert B. Bradley, M.D.		23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.		23D. ADDRESS 4900 Belair Road 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/72	
24C. NAME OF CEMETERY or CREMATORY Oaklawn		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leona rd J. Ruck Inc.		ADDRESS Ba lto. Md.	

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

XXXXXXXXXXXX 135 N. Broadway

John Thomas H. Hunk

Anna

Pullerton & Hays Funeral Home

Service scheduled for Friday

Funeral home used in case

Clayton, Pa.

St. John's

Funeral

Funeral home used in case

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-120		72 02555		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02555	
1. NAME OF DECEASED (Type or Print) John B. Bavis				2. DATE AND HOUR OF DEATH 3/10/72 12:30 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harford Gardens Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2716 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2709 The Alameda 3418 St. Ambrose Ave			
5. SEX M.	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 20, 1878		9. AGE (In years last birthday) 94 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Produce Business				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Bavis				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-32-9708		17. INFORMANT ADDRESS Miss Mildred Bavis 2709 The Alameda	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. art scler v disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: art scler v disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/12/1968 to 3/10/1972 , that (I) (we) last saw the deceased alive on 3/10/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Maurice Feldman MD						23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) Maurice Feldman MD				23D. ADDRESS 6610 Cross Country Blvd. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, Md.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.			

S-536

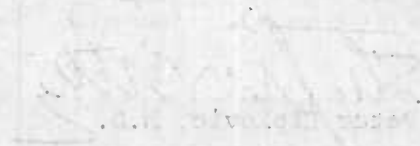
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02556

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dorothy E. Schnieder		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 3 11 72		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4020 Ridgcroft Road		3. DATE PRONOUNCED DEAD Month Day Year 3 11 72		Hour 8:58 A.M.
6. SEX female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH Aug. 15, 1889		10. AGE (In years last birthday) 82		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Frederick Schwear		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
15. MOTHER'S MAIDEN NAME Wilhelmina Fethe		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-10-2632D
18. INFORMANT Mr Norman Schneider		19. ADDRESS 4007 Biddison La		20. CAUSE OF DEATH Hypertensive + Arteriosclerotic Cardiovascular disease
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.2		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. DATE OF OPERATION 0		26. CONDITION FOR WHICH OPERATION WAS PERFORMED
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/11/72
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/72		24C. NAME OF CEMETERY or CREMATORY Oaklawn
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Deonard J. Ruck Inc.
25C. FUNERAL DIRECTOR Deonard J. Ruck Inc.		25D. ADDRESS Baltimore, Md		

25-10-2020 BY ACTING SUPERVISOR 1007
MILWAUKEE
FREDERICK SCHWARTZ
1000 ALLEGHENY RD
MILWAUKEE, WISCONSIN 53211
NO



25-10-2020 BY ACTING SUPERVISOR 1007
MILWAUKEE
FREDERICK SCHWARTZ
1000 ALLEGHENY RD
MILWAUKEE, WISCONSIN 53211
NO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-550		72 02557		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02557	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				RAYMOND E CANNON		2. DATE AND HOUR OF DEATH March 11, 1972 5:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Maryland 1202	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
00 3206 Abell Avenue				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3206 Abell Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
male	caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-25-88	83			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
carpenter			retired		Penna.		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John F. Cannon				Bridget Early			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				183-12-5034		Mrs. Rita Glisson, 3206 Abell Ave, Balto, Md.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic CV Disease 10 yrs</i>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				no			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-14 1962 to 3-11 1972, that (I) (we) last saw the deceased alive on 3-2 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Frederick J. Vollmer M.D.				3-11-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Frederick J. Vollmer				6100 N York Road, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/14/72		New Cathedral		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 14 1972		Reed, R. J.		Leonard J. Buck, Inc. - Balto, Md. - 14			

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

1973

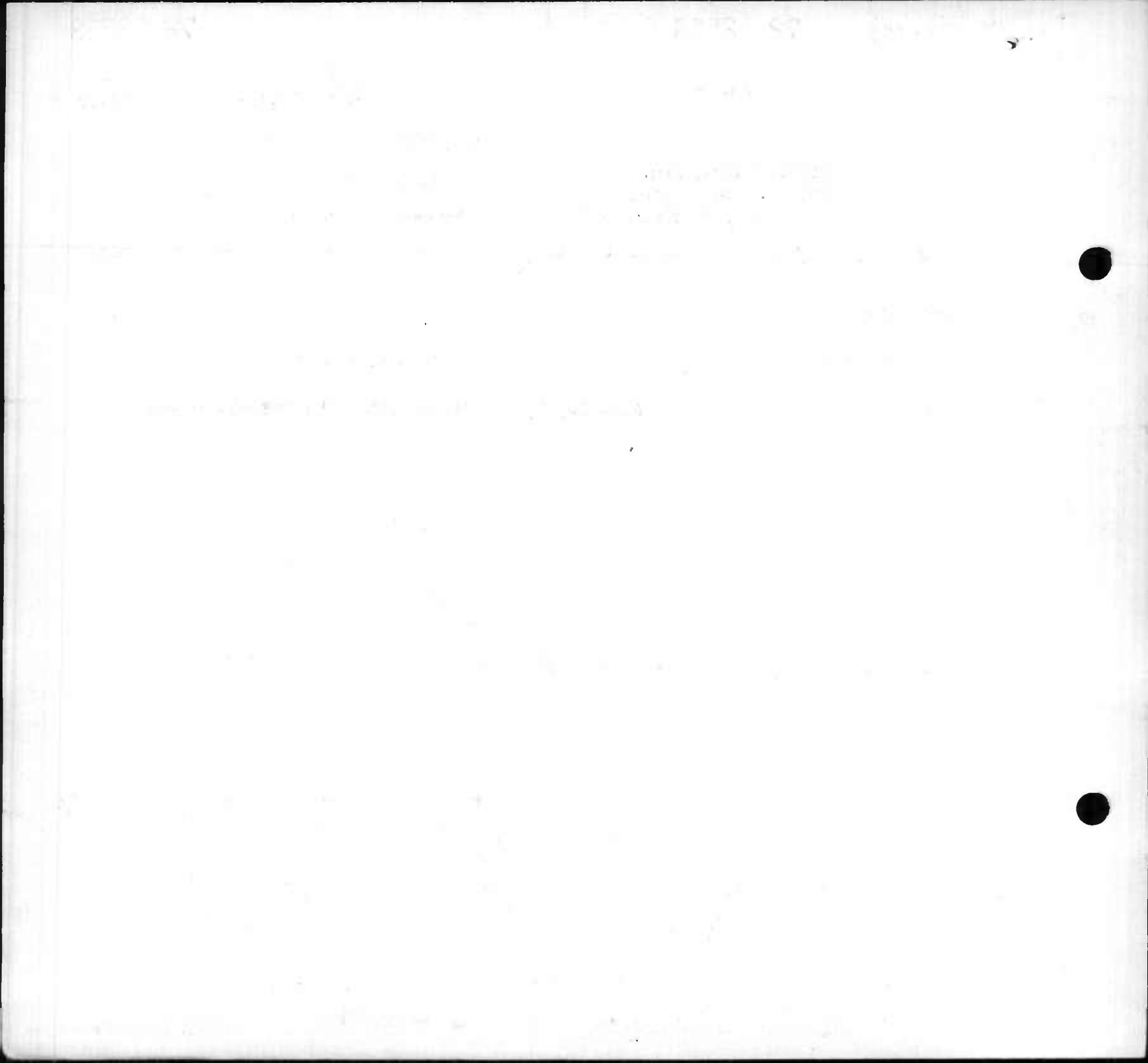
1973

1973

1973

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-100		72 02558		BALTIMORE CITY HEALTH DEPARTMENT		72 02558	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Stefan SEBO				March 10, 1972 11:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90				A. STATE Maryland			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202				B. COUNTY 2646			
5. SEX M				6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 10/24/89		9. AGE (In years last birthday) 82	
Brick Layer				11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Sebo				14. MOTHER'S MAIDEN NAME Victoria Senesi			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 110-01-3275		17. INFORMANT Victor Sebo 6802 Roberts Avenue			
18. CAUSE OF DEATH 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V. Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension		?	
				(C) DUE TO, OR AS A CONSEQUENCE OF: Congestive Failure		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				C.V.A. C.H.D. Feb 9-1972			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/19 1971 to 3/10 1972 that (I) (we) last saw the deceased alive on March 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Bloom MD				23B. DATE SIGNED 3/10/72		23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLOOM MD	
23D. ADDRESS 1115 N. CALVERT ST				23E. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR WALTER DABROWSKI 1005 DUNDALK AVENUE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02559	
<div style="display: flex; justify-content: space-between;"> H-463 72 02559 </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div>					
1. NAME OF DECEASED (Type or Print) Hilliard Gregory Lynn			2. DATE AND HOUR OF DEATH 3/10/72 16:17 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Washington		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital			C. CITY OR TOWN Hagerstown		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 671 Highland Way		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/72	9. AGE (In years last birthday) 3	10. Under 1 Yr. Months: Days: Hours: Min. 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant			11. BIRTH PLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Donald L. Hilliard			14. MOTHER'S MAIDEN NAME Betty Jane Payne		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Donald L. Hilliard
			ADDRESS 671 Highland Way Hagerstown, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 746.1 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE Hypoxemia DUE TO, OR AS A CONSEQUENCE OF: (B) Transposition of the Great Vessels DUE TO, OR AS A CONSEQUENCE OF: (C) [REDACTED]		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/8 19 72 to 3/10 19 72 that (1) (we) last saw the deceased alive on 3/10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) THOMAS HOFFMAN				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1972 March 13		24C. NAME of CEMETERY or CREMATORY Rosedale Cemetery	
				24D. LOCATION (City, town, or county) (State) Martinsburg, West Va.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Howard K. Brown ADDRESS Howard K. Brown - Martinsburg, W. Va.	

x

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

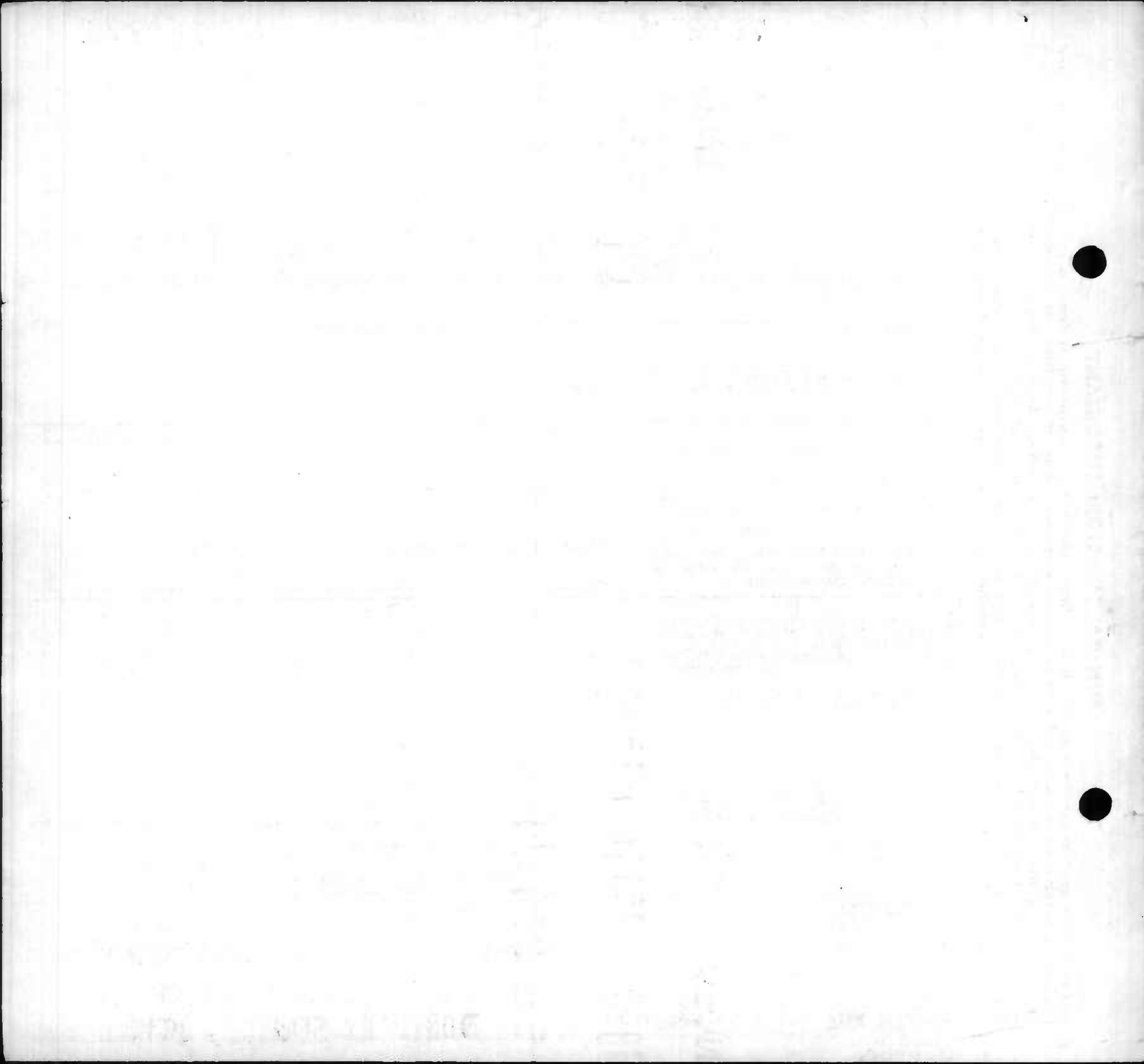
BIRTH NO. K-620		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02560
1. NAME OF DECEASED (Type or Print) Eugene P Kress		2. DATE AND HOUR OF DEATH March 10 1972 12:30 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6558 St Helena Ave		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland 8. COUNTY 2636 C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> STREET AND NUMBER 6558 St Helena Ave		
5. SEX male 6. RACE cacasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 1 1919 9. AGE (In years last birthday) 52		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Penn Cen Railroad		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Kress		
14. MOTHER'S MAIDEN NAME Margaret		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2		
16. SOCIAL SECURITY NO. 220-9-7466		17. INFORMANT Mary I. Mrs Margaret Kress 6558 St Helena Ave		
18. 162,11 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the neck Carcinoma of lung with metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 1-30-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 1960 to 1972 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1-30-72 to 1-30-72 and that (I) (we) lost saw the deceased alive on 1-29-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 3-10-72 12:30 a.m.				
23A. SIGNATURE Eugene F Navy MD		23B. DATE SIGNED 3-11-72		
23C. PHYSICIAN'S NAME (Type) Eugene F Navy MD		23D. ADDRESS 7001 MORNINGTON RD.		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Mar 13/72		
24C. NAME OF CEMETERY or CREMATORY Moreland Men		24D. LOCATION (City, town, or county) (State) Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR John E. Kelly, MD.		
25C. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md. 21222		ADDRESS		

3-20-1972 - Correction form from Funeral Director - HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		72 02561		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02561	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) IRVING GREENE		2. DATE AND HOUR OF DEATH 2/27/72 8:00 P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GEN. HOSPITAL				A. STATE MD. B. COUNTY BALTO		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1700 Johns St					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/89	9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MD. GEN. HOSPITAL INFO SHEET			
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma Colon 3 yrs? (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Small intestinal obstruction									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 2/18 19 72 to 2/27 19 72 that (1) (we) last saw the deceased alive on 2/27/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Karl F. Meach Jr. M.D.				23B. DATE SIGNED 2/27/72					
23C. PHYSICIAN'S NAME (Type) KARL F. MEACH, JR. M.D.				23D. ADDRESS MD. GENERAL HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-3-72		24C. NAME OF CEMETERY or CREMATOR ANATOMY BOARD OF MARYLAND		24D. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL		25D. ADDRESS MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-540 72 02562 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02562	
BIRTH NO. 1					
1. NAME OF DECEASED (Type or Print) Connolly, Stephen			2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 2-21-72 12:20 P M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> CERTIFICATE AMENDED NO. 39 HOSPITAL OR INSTITUTION ADDRESS OR LOCATION Provident Hospital Complex 2600 Liberty Hgts. Baltimore, Md. </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1510		
5. SEX Male			6. RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 8-9-04		
9. AGE (In years last birthday) 67			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Steamfitter		
11. BIRTHPLACE (State or foreign country) Ireland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes WW II-U.S. Army			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Nancy C. Fibish-101 S. Whiting St., Alexandria, Va. 22304			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable Pulmonary Tuberculosis Unknown (B) DUE TO, OR AS A CONSEQUENCE OF: No Lung Cancer Unknown (C) PLEURISY & EFFUSION, MASSIVE Unknown			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION 0 none			20. AUTOPSY? (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 2-9-72 to 2-21-72 and that (I) (we) last saw the deceased alive on 2-21-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aurora C. Tan, M.D.			23B. DATE SIGNED 2-28-72		
23C. PHYSICIAN'S NAME (Type) AURORA C. TAN, M.D.			23D. ADDRESS PROVIDENT HOSPITAL Baltimore, Md. 21215		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Aug. 26, 1972		
24C. NAME OF CEMETERY OR CREMATOR New Cathedral			24D. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972			25B. NAME OF REGISTRAR Robert E. Barber, R.D. 2		

1: Letter from Henry W. Jenkins, Funeral Directors re place & date of burial.

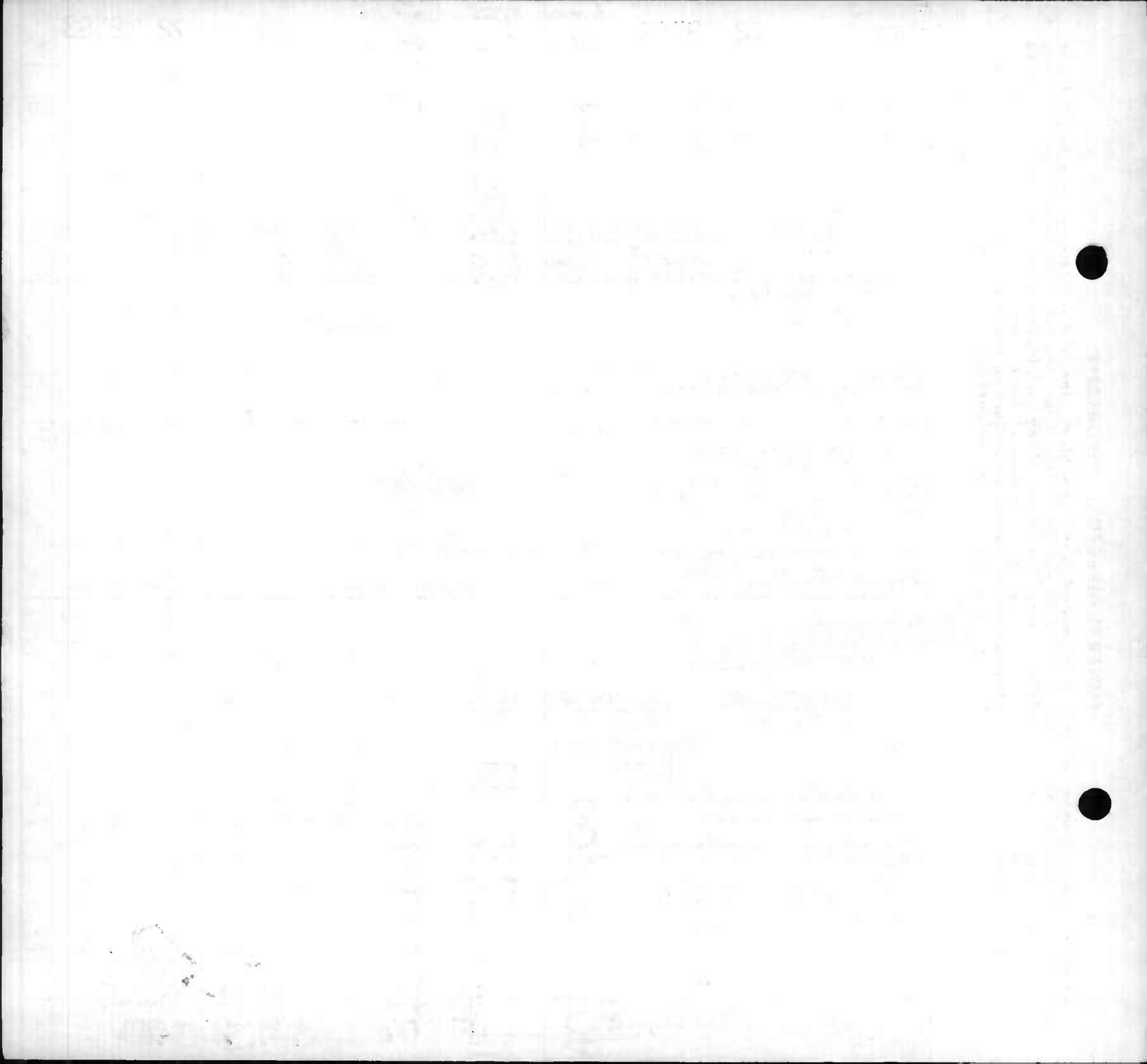
2: 9-15-1972 - Correction letter from Funeral Director, Henry W. Jenkins & Sons, Co. Balto., Md. & Enlisted Record and Report of Separation-Honorable Discharge - date of separation Aug. 13, 1945, Fort George G. Meade, Md. U.S. Army. Serial No. 33 380 647.

Certificate of Citizenship No. 2929091, dated May 13, 1929-U.S. District Court for the District of Maryland. HS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-525		72 02563		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02563	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Helge Pinkney</u>			
2. DATE AND HOUR OF DEATH <u>2/23/72</u> <u>10:10 P.M.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1538</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>3619 Springdale Ave</u>	
5. SEX <u>Male</u>	6. RACE <u>Black</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-01-01</u>	9. AGE (in years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>911-18-9454</u>		17. INFORMANT <u>Pt. Record</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cachexia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Malnutrition + dehydration</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Wernia</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>Feb.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. G. Mercado</u>				23B. DATE SIGNED <u>Feb. 23, 72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. G. MERCADO MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-6-72</u>		24C. NAME OF CEMETERY or CREMATORY		24D. ADDRESS <u>PROVIDENT HOSP. Balto. Md. 21215</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. NAME OF FUNERAL HOME <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCTD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

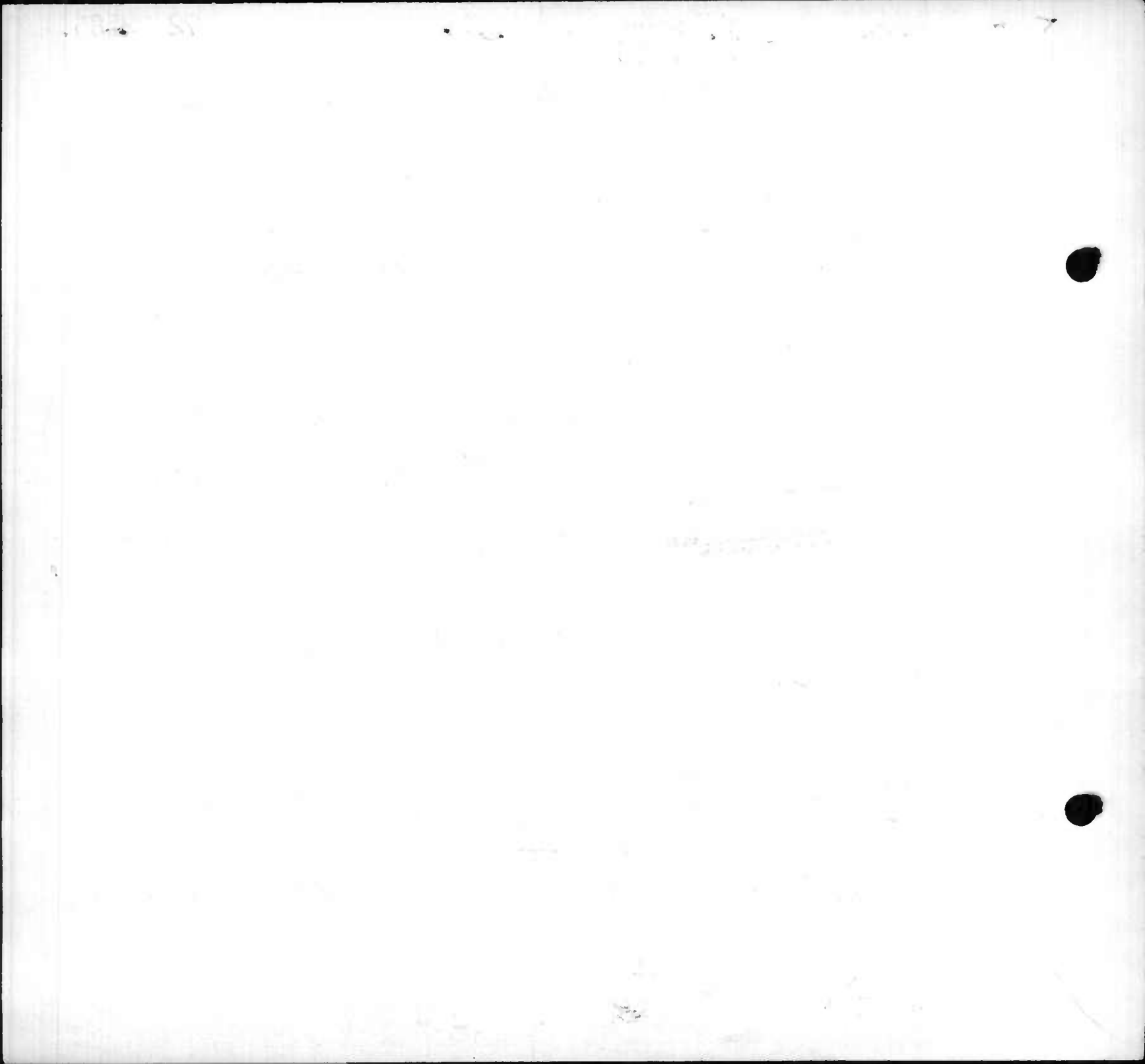
<p>B-355 72 02564 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>72 02564</p>	
<p>BIRTH NO.</p>		<p>REG. NO.</p>	
<p>1. NAME OF DECEASED (Type or Print) REDMOND CHRISTOPHER.</p>		<p>2. DATE AND HOUR OF DEATH 3/10/72 1 3:00 P M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY V43</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.</p>		<p>C. CITY OR TOWN WEEMS D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>E. STREET AND NUMBER None</p>			
<p>5. SEX M</p>	<p>6. RACE N</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 6/25/14</p>
<p>9. AGE (in years last birthday) 57</p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY MERCHANT MARINES</p>	
<p>11. BIRTHPLACE (State or foreign country) VIRGINIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME JEREMIAH REDMOND.</p>		<p>14. MOTHER'S MAIDEN NAME MARY ELIZABETH MEUSE</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 229-24-5464</p>	
<p>17. INFORMANT M. H. KELEMEN, MD.</p>		<p>ADDRESS</p>	
<p>18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial infarction (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 4 yrs.</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 10/25 1970 to 3/10 1972 that (I) (we) last saw the deceased alive on 2/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>[Signature]</i> M.D.</p>		<p>23B. DATE SIGNED 3/11/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) MICHAEL H. KELEMEN M.D.</p>		<p>23D. ADDRESS USPS HOSP, BALT, Md</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3/15/72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Sharon B.C.</p>		<p>24D. LOCATION (City, town, or county) (State) Weems Va</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972</p>		<p>25B. NAME OF REGISTRAR Robert E. Jaber, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Elison - 1348 N. Calhoun St</p>		<p>ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02565		REG. NO.	
1-510				72 02565		CERTIFICATE OF DEATH	
BIRTH NO.				11 March 72 1415 M.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lamb, Richard K.				Md 1 1301 21219			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE 8. COUNTY			
48 Maryland General Hospital				Md 1 1301 21219			
5. SEX				6. RACE			
MALE				NEGRO			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				14 Mar 79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
N. Carolina				U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Lamb							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				214-01-0749			
17. INFORMANT				ADDRESS			
Annie Lamb				Same			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				FRACTURE OF NECK			
CERTIFICATION AND DISCUSSION OF CAUSE OF DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
This declaration is made by a physician, e.g., heart failure, asthma, etc. if medical disease, injury or complication, such as, etc.				Sudden death - Sudden death - Sudden death			
CHIEF OR ASSISTANT MEDICAL EXAMINER				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II				Traumatic dislocation of C-5			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				814 Brooks Lane 1301			
22. I certify that (this hospital) attended the deceased from 5 Mar 1972 to 11 Mar 1972				that (we) lost saw the deceased alive on 11 Mar 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Wm Gregory Brum				11 Mar 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Bucial				3-15-72			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
ARBUS MEm. PK.				BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAR 14 1972				Robert E. Bailey, MD			
25C. FUNERAL DIRECTOR				ADDRESS			
U. BAILLEY				KELSON F. H. 1348 CACHOWN ST.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

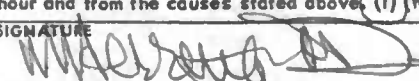
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02566	
<div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED (Type or Print) 2. DATE AND HOUR OF DEATH </div> <div style="display: flex; justify-content: space-between;"> PARKER, OLIVIA FLORENCE MARCH 9, 1972 10:30 A.M. </div>					
<div style="display: flex; justify-content: space-between;"> 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) </div> <div style="display: flex; justify-content: space-between;"> ST AGNES HOSPITAL MARYLAND </div>			<div style="display: flex; justify-content: space-between;"> 5. SEX 6. RACE </div> <div style="display: flex; justify-content: space-between;"> FEMALE NEGRO </div>		
<div style="display: flex; justify-content: space-between;"> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH </div> <div style="display: flex; justify-content: space-between;"> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 02/29/1915 </div>			<div style="display: flex; justify-content: space-between;"> 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) </div> <div style="display: flex; justify-content: space-between;"> 57 </div>		
<div style="display: flex; justify-content: space-between;"> 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? </div> <div style="display: flex; justify-content: space-between;"> MARYLAND U S A </div>			<div style="display: flex; justify-content: space-between;"> 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME </div> <div style="display: flex; justify-content: space-between;"> WATERS, HARRY JOHNSON, LILLEY </div>		
<div style="display: flex; justify-content: space-between;"> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. </div> <div style="display: flex; justify-content: space-between;"> no </div>			<div style="display: flex; justify-content: space-between;"> 17. INFORMANT 18. CAUSE OF DEATH </div> <div style="display: flex; justify-content: space-between;"> CATON AVES. BALTO. MD. 21229 from brain left middle cerebral artery </div>		
<div style="display: flex; justify-content: space-between;"> 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED </div> <div style="display: flex; justify-content: space-between;"> 2 </div>			<div style="display: flex; justify-content: space-between;"> 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> <div style="display: flex; justify-content: space-between;"> YES </div>		
<div style="display: flex; justify-content: space-between;"> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inkily medical examined) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) </div> <div style="display: flex; justify-content: space-between;"> </div>			<div style="display: flex; justify-content: space-between;"> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) </div> <div style="display: flex; justify-content: space-between;"> </div>		
<div style="display: flex; justify-content: space-between;"> 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED </div> <div style="display: flex; justify-content: space-between;"> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div>			<div style="display: flex; justify-content: space-between;"> 21F. HOW DID INJURY OCCUR? </div> <div style="display: flex; justify-content: space-between;"> </div>		
<div style="display: flex; justify-content: space-between;"> 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 22, 1972 to MARCH 9, 1972 </div> <div style="display: flex; justify-content: space-between;"> that (I) (we) last saw the deceased alive on MARCH 9, 1972 </div> <div style="display: flex; justify-content: space-between;"> and that (I) (my) (our) opinion death occurred on the date </div> <div style="display: flex; justify-content: space-between;"> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. </div>					
<div style="display: flex; justify-content: space-between;"> 23A. SIGNATURE 23B. DATE SIGNED </div> <div style="display: flex; justify-content: space-between;"> S. San Pedro, M.D. </div>			<div style="display: flex; justify-content: space-between;"> 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS </div> <div style="display: flex; justify-content: space-between;"> S. SAN PEDRO, M.D. BALTIMORE, MD. 21229 </div>		
<div style="display: flex; justify-content: space-between;"> 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE </div> <div style="display: flex; justify-content: space-between;"> Burial 3-13-72 </div>			<div style="display: flex; justify-content: space-between;"> 24C. NAME of CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State) </div> <div style="display: flex; justify-content: space-between;"> Western Star Cemetery Balto. Md. </div>		
<div style="display: flex; justify-content: space-between;"> 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR </div> <div style="display: flex; justify-content: space-between;"> MAR 14 1972 </div>			<div style="display: flex; justify-content: space-between;"> 25C. FUNERAL DIRECTOR ADDRESS </div> <div style="display: flex; justify-content: space-between;"> Nelson F.H. 1348 Calhoun Street </div>		

3/14/72 - Correction form from funeral director.

AGC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02567	
1. NAME OF DECEASED (Type or Print) Christine White		2. DATE AND HOUR OF DEATH 3/12/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 333		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 805 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1742 E. 25th			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/14		9. AGE (In years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME SAM RICE			14. MOTHER'S MAIDEN NAME ANNIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 243-01-4754		17. INFORMANT SANDY WHITE ADDRESS 1742 E. 25th ST	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 200.0 ! RETICULUM CELL SARCOMA 1 yr APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/7 19 72 to 3/12 19 72 that (I) (we) last saw the deceased alive on 3/7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 3/7/72	
23C. PHYSICIAN'S NAME (Type) Malcolm Heuring MD		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/72		24C. NAME of CEMETERY or CREMATORY mt. Calvary	
24D. LOCATION (City, town, or county) (State) a. a. County Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Joseph P. Lock ADDRESS 1304 N. Central Ave			

28 3/4 N.C.

Domestic

28-01-1942 2nd 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th 13th 14th 15th 16th 17th 18th 19th 20th 21st 22nd 23rd 24th 25th 26th 27th 28th 29th 30th 31st

h

James E. Smith and Company
Joseph E. Smith & Sons

G-615

72 02568

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02568

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clara Isabella Griffin		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 10 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 10 72 11:15 a. M.	
6. SEX female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1803
9. DATE OF BIRTH Jan 12-1890	10. AGE (In years lost birthday) 82	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY U.S.A.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME CLARA SCHAUB
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and of unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 21722107	18. INFORMANT ADDRESS CHAS. GRIFFIN SAME
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-13-72	
24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK		24D. LOCATION (City, town, or county) (State) WOODLAWN MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR R. G. J. J. J.	
25C. FUNERAL DIRECTOR B. SCHWAB		ADDRESS 2101 FRED. AVE.	

15-503

25 1282

X

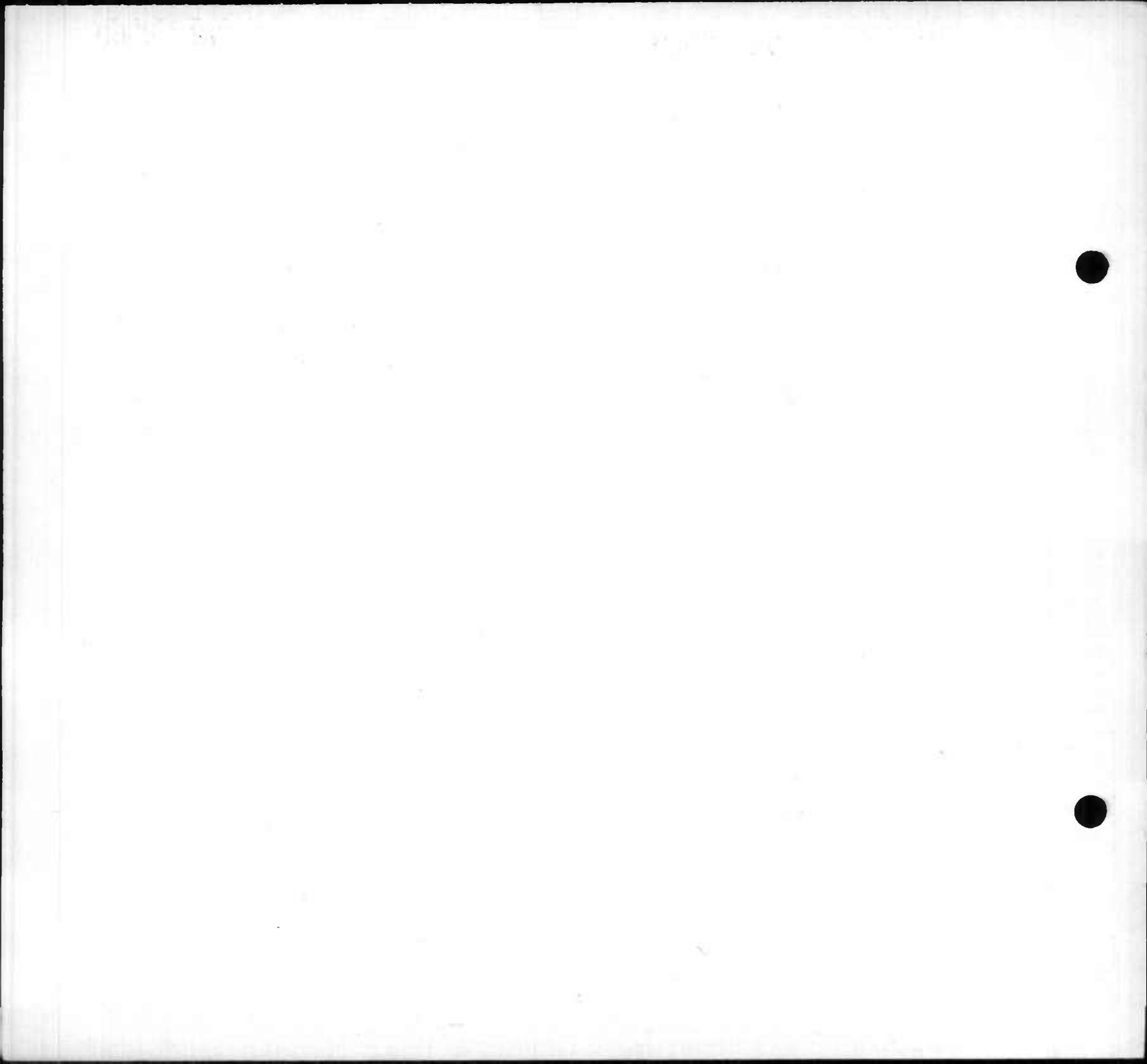
X

JOSEPH KLEIN
CLARA SCHWAB
JOSEPH KLEIN
CLARA SCHWAB

JOSEPH KLEIN
CLARA SCHWAB

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200		72 02569		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02569	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) MACK, WILLIE				2. DATE AND HOUR OF DEATH 3/11/72 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL 34				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1901			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1633 W. LEXINGTON ST.			
5. SEX MALE	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/12/32	9. AGE (In years last birthday) 39	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MACK				14. MOTHER'S MAIDEN NAME Gimmie Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 3-3-53, 3-29-55		16. SOCIAL SECURITY NO. 247-54-6346		17. INFORMANT ADDRESS Mrs. Louise Stepp 522 W. Hoffman St. 21201 PT. CHART			
18. 486X 17303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PNEUMONIA (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH PNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC ALCOHOLISM				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from March 10 19 72 to March 11 19 72 that (I) (we) last saw the deceased alive on March 11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Malinee Yunongying				23B. DATE SIGNED 3-11-72			
23C. PHYSICIAN'S NAME (Type) MALINEE YUNONGYING				23D. ADDRESS B5H			
24A. BURIAL CREMATION, REMOVAL (Specify) transit-burial		24B. DATE 3-15-1972		24C. NAME of CEMETERY or CREMATORY Gettysburg National		24D. LOCATION (City, town, or county) (State) Gettysburg, Pa.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS Marshall W. Jones, Jr.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hsp Hl
4940 Eastern Ave. 21224 Baltimore, Md.

5. SEX

6. RACE

Male

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-26-1889

9. AGE (in years last birthday)

82

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer (Retired)

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jocham

14. MOTHER'S MAIDEN NAME

Maria

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes 7/18 to 6/19

16. SOCIAL SECURITY NO.

213-07-6350A

17. INFORMANT

BCH Records:

4940 Eastern Ave.
Baltimore, Md. 21224

ADDRESS

4940 Eastern Ave.
Baltimore, Md. 21224

18. 433.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from Feb 11 to Feb 11 1972 that (B) (we) last saw the deceased alive on Feb 11 1972 and that (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

A. MAKART

M.D.

Attending Phys. ☒Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

3/12/72

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-15-72

24C. NAME OF CEMETERY or CREMATORY

Greek Orthodox Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

4-19-72

25B. NAME OF REGISTRAR

Robert E. Talley, Jr.

25C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3021 Eastern Ave., Baltimore, Md.

11/25/11

from

11/25/11

11/25/11

11/25/11

11/25/11

11/25/11

11/25/11

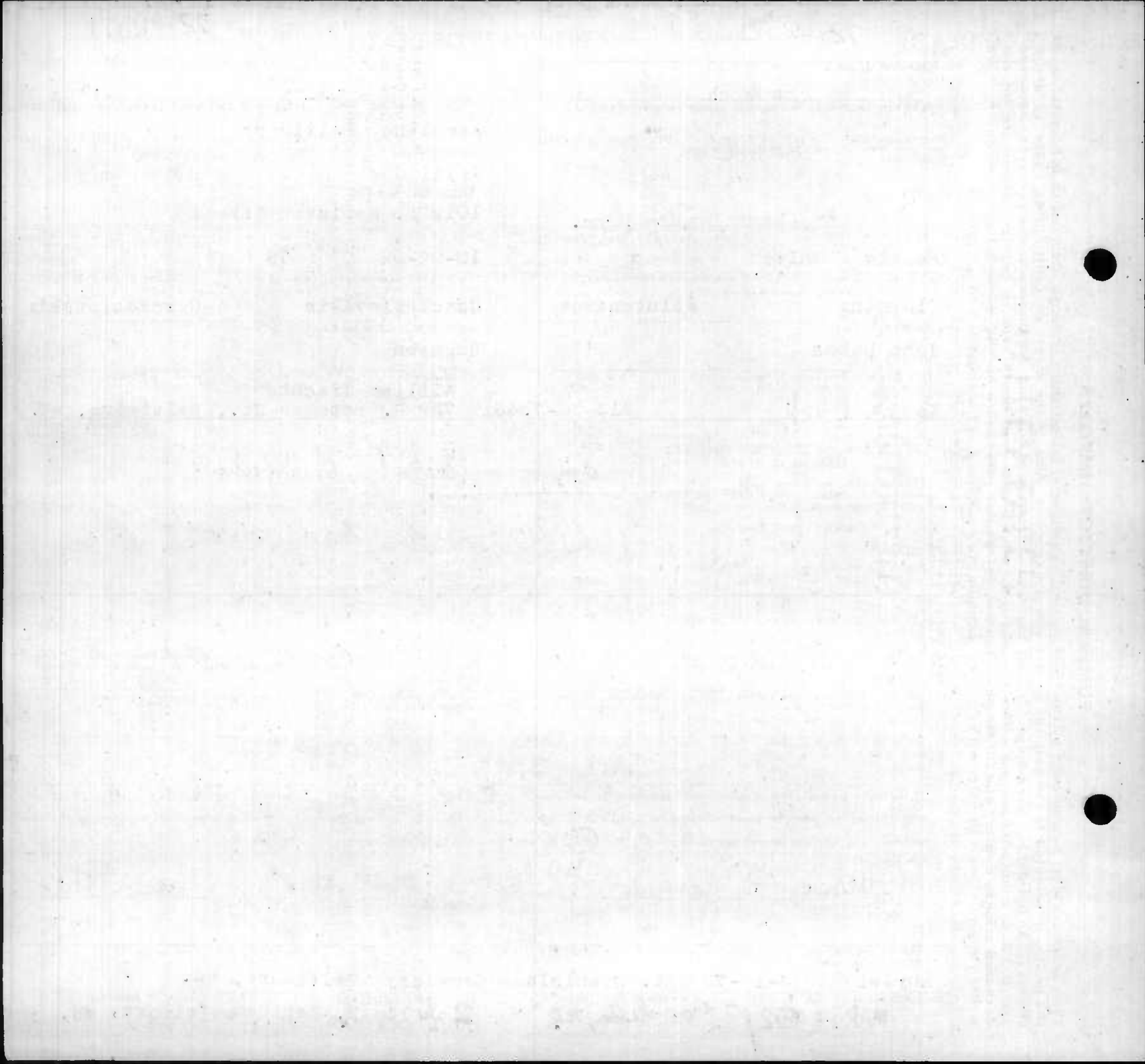
11/25/11

11/25/11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02571	
BIRTH NO. 72 02571		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Anna Kmoch			2. DATE AND HOUR OF DEATH 3-9-72 5:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital, Inc.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 37			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1012 S. Robinson Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaning		10B. KIND OF BUSINESS OR INDUSTRY Maintenance		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
13. FATHER'S NAME John Dobos			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-30-7545A		17. INFORMANT William Trachta ADDRESS 739 S. Potomac St., Baltimore, Md.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis (B) Arteriosclerotic heart disease (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 3 19 72 to March 9 19 72 , that (I) (we) last saw the deceased alive on March 9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Picamor F. Joagun MD				23B. DATE SIGNED March 9/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972			
25B. NAME OF REGISTRAR W. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Nicholas T. Matthews ADDRESS 6021 Eastern Ave., Baltimore, Md.			



1
W 623

72 02572

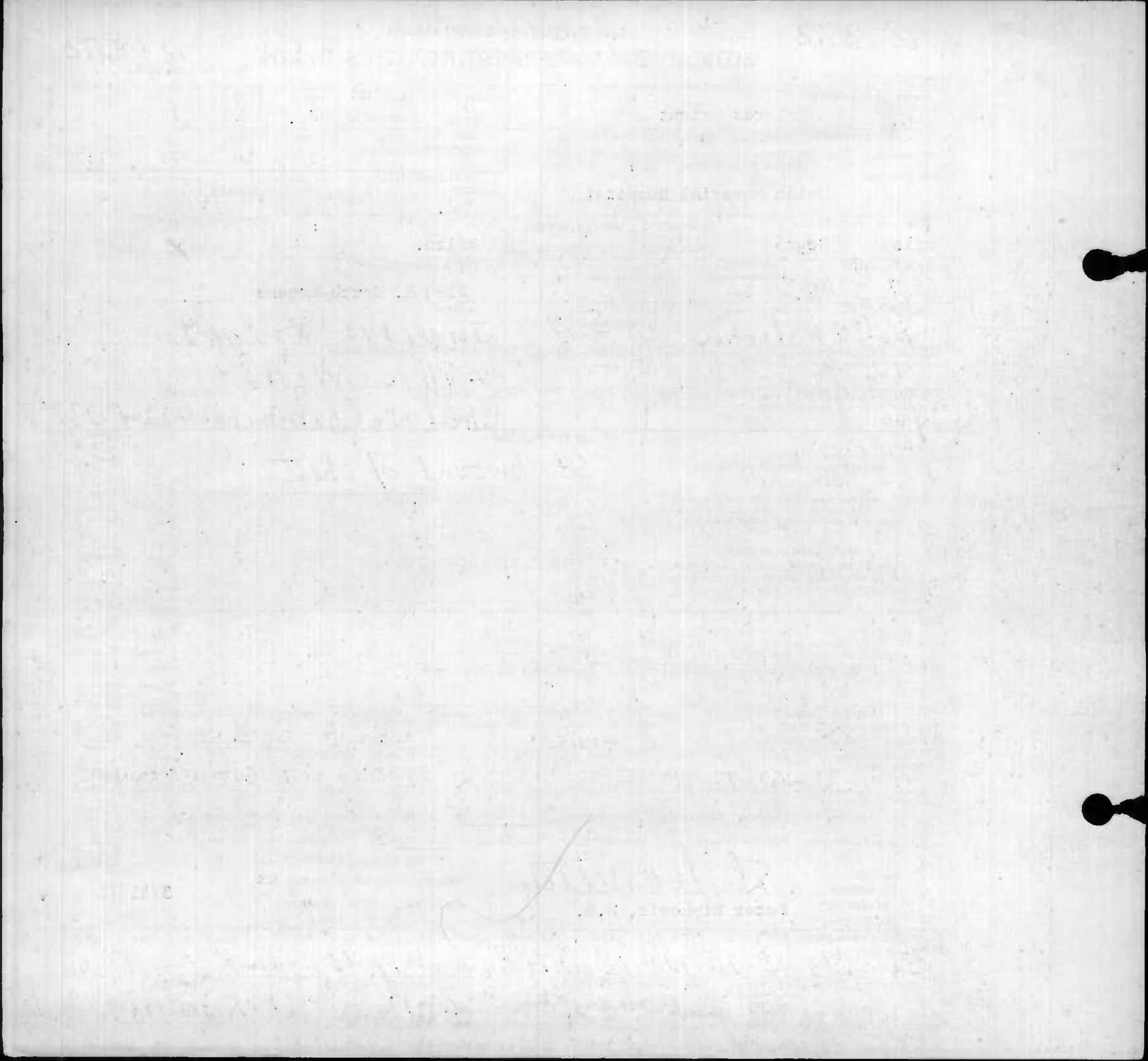
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02572

REG. NO.

1. NAME OF DECEASED (Type or Print) Lores Wright		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 10 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 10 72 11:30 P.M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1205	
9. DATE OF BIRTH Oct. 3, 1923		10. AGE (In years last birthday) 48	
11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Junious Wright		14. MOTHER'S MAIDEN NAME Lillie Wells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Chestine Chambers		ADDRESS 422 E. 23rd St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 966X 1 Stabwound of chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 422 E 23rd St 1204		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3 10 72 11:30 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? STABBED WITH BUTCHER KNIFE	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 3/11/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-72	
24C. NAME OF CEMETERY or CREMATORY BALTO. Cemetery		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR MEITON & ELICKSON		ADDRESS 1129 N. Caroline	



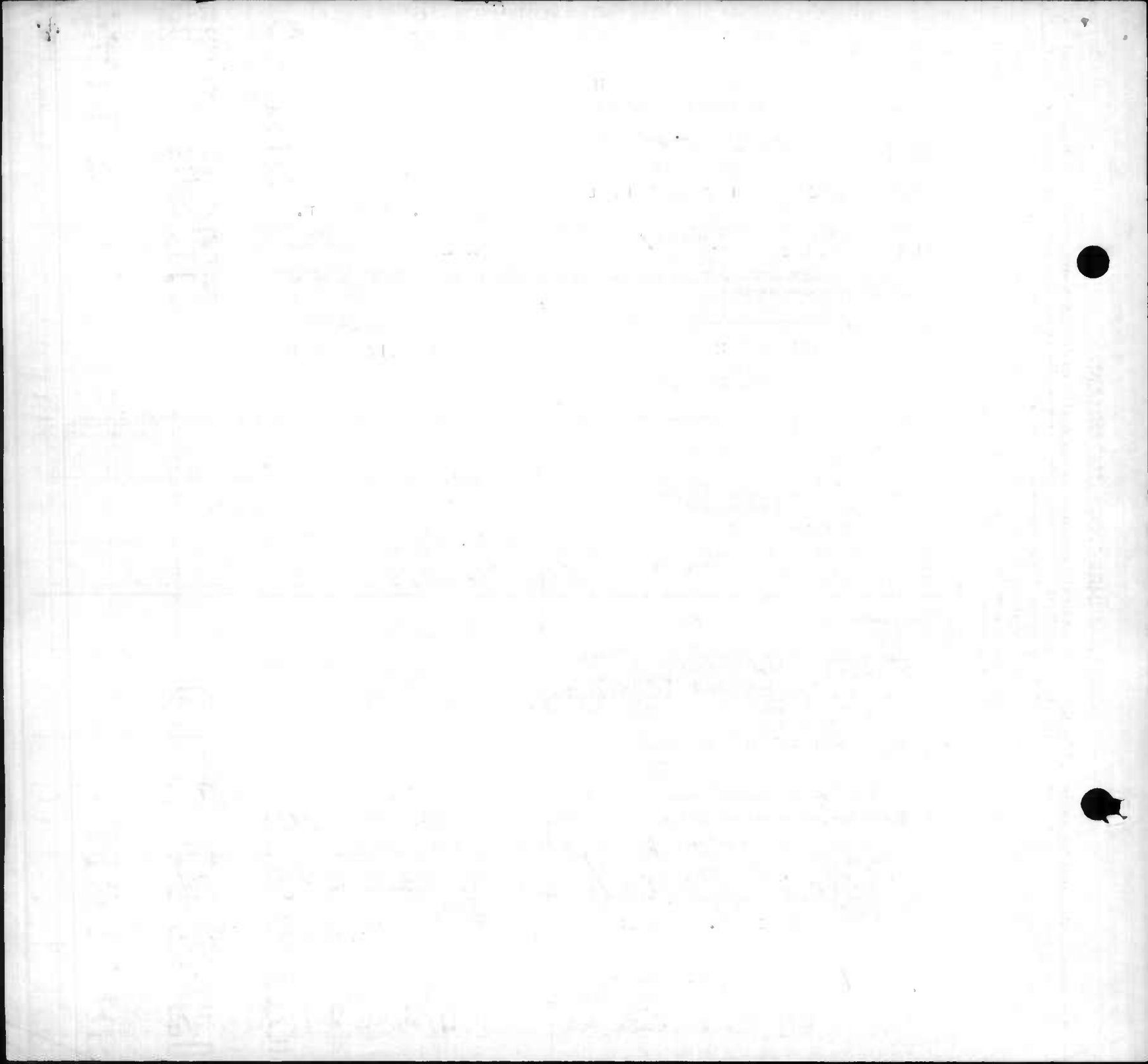
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decedent was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. **72 02573**

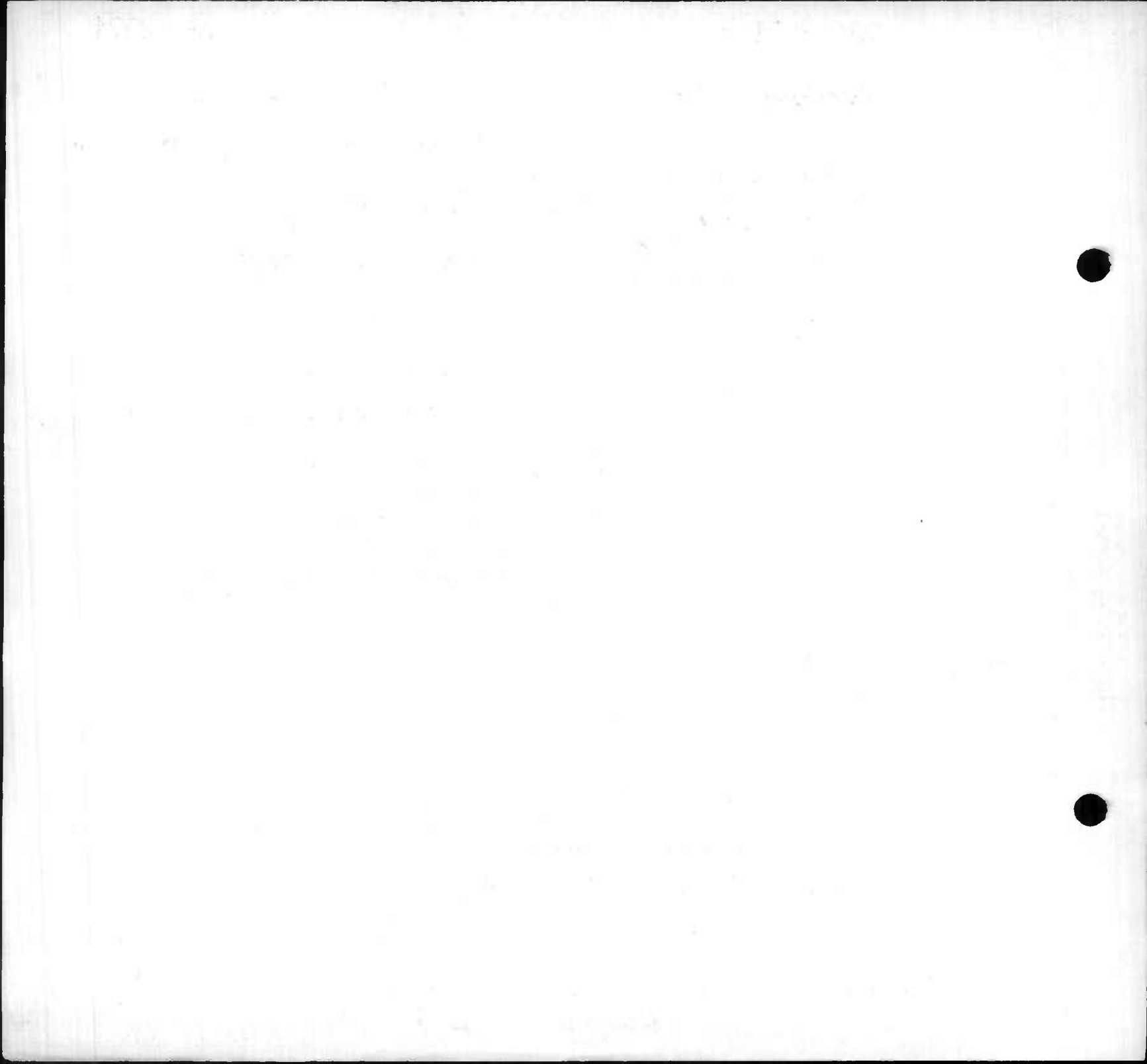
BIRTH NO. **72 02573**

1. NAME OF DECEASED (Type or Print) JAMES GREEN		2. DATE AND HOUR OF DEATH 3/9/72 6:15 pm		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 908		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 506 E. 20TH ST.		5. SEX MALE		6. RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-10		9. AGE (In years last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOHN GREEN		14. MOTHER'S MAIDEN NAME CECELIA MASON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-2533		17. INFORMANT Margaret Smith-506 E. 20th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 157.9 I Radio-Respiratory Arrest Progressive Cerebral Dysfunction Secondary to stroke Cc pancreas		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Cancer Pancreas		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 2/25/72 19 72 to 3/9 19 72 and that (we) last saw the deceased alive on 3/9 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Noble M. Hansen		23B. DATE SIGNED 3/9/72		23C. PHYSICIAN'S NAME (Type) NOBLE M. HANSEN	
23D. ADDRESS Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-72	
24C. NAME OF CEMETERY OR CREMATORY St. George Cemetery		24D. LOCATION (City, town, or county) (State) St. Mary's County, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972	
25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR MORTON E. ELICKSON-1219 N. Caroline St.		25D. ADDRESS	



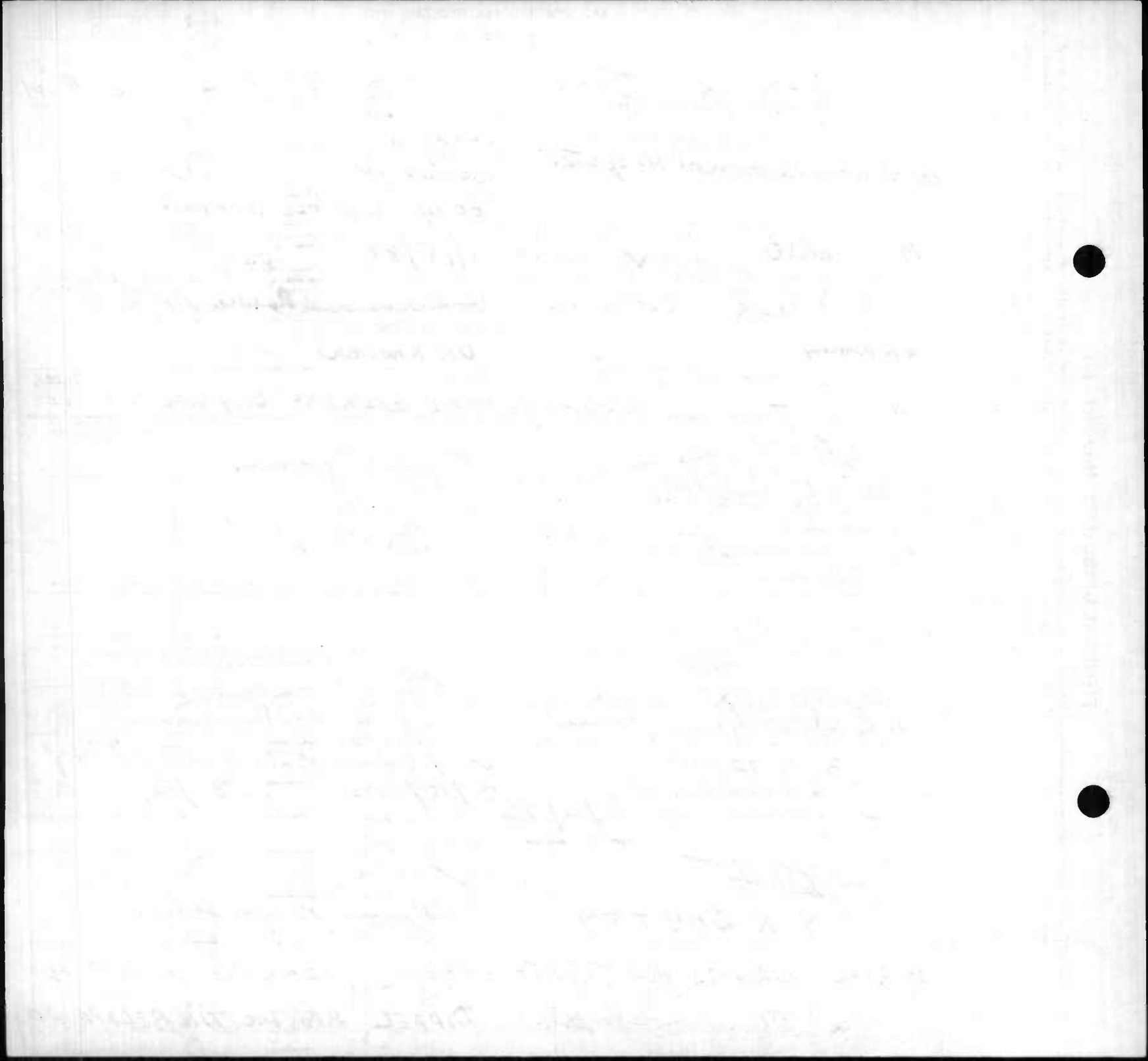
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02574		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02574	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RINDA ENNALS		2. DATE AND HOUR OF DEATH March 12-1972 5:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2710		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Mt Sinai Nursing Home 4613 Park Heights Ave Baltimore MD 21215		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 558 Radnor Ave	
5. SEX FEMALE	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 20-1887	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Bessy Lewis		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-0966		17. INFORMANT Herman Ennals	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 7 19 72 to March 12 19 72 that (I) (we) last saw the deceased alive on March 12 19 72 and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE Louis T. Lavy M.D.		23B. DATE SIGNED March 12-1972		23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-17-72		24C. NAME of CEMETERY or CREMATORY John Wesley United Meth.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR William E. Eliekson	
24D. LOCATION Burial		24E. LOCATION Porchester County, Md.		24F. ADDRESS 1129 N. Cardine St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02575</u>	
BIRTH NO. <u>72 02575</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MAXIMUK JOHN</u>			2. DATE AND HOUR OF DEATH <u>March 12 1972</u> <u>6 P M</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2744</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u> <u>44</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>6014 Walther Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/15/88</u>	9. AGE (In years last birthday) <u>84 y</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rehired TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u> <u>1ST PAPERS</u>
13. FATHER'S NAME <u>UN KNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UN KNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-096607A</u>	17. INFORMANT <u>MARIE ZELINSKY 6014 WALTHER AVE</u> ADDRESS <u>21206</u>		
18. DISEASE OF CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., but the disease, injury or complication which caused death.) <u>E 880X</u> <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory arrest -</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Fx of neck with</u> (B) <u>Fracture cervical spinal cord</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>body released by him</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>house</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>6014 Walther Avenue</u>	
21D. TIME OF INJURY (APPROX.) <u>3 10 72 730 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell down flight of stairs 2744</u>	
22. I certify that (H) (this hospital) attended the deceased from <u>3/10/1972</u> to <u>3/12/1972</u> that (I) (we) last saw the deceased alive on <u>3/12/72</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Y. K. Shetty</u>				23B. DATE SIGNED <u>3/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Y. K. SHETTY</u>				23D. ADDRESS <u>Union Memorial Hosp Baltimore, Maryland 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>MAR 16-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY TRINITY CEMETERY</u>	
24D. LOCATION <u>ELK RIDGE HOWARD MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>			
25B. NAME OF REGISTRAR <u>E. J. Baker, MD.</u>		25C. FUNERAL DIRECTOR <u>DIPPEL BROS INC 7110 BELAIR RD</u>			



1
K530

BALTIMORE CITY HEALTH DEPARTMENT

72 02576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02576

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel Kennedy		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72 Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1030 Sharp St. (So.)		3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72 Hour 9:50 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2301			
6. SEX male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/28/26		10. AGE (In years last birthday) 45	
11. BIRTHPLACE (State or foreign country) Winnaboo S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIE KENNEDY		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Mary HARR		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO. 248-38-1123		18. INFORMANT ADDRESS 440 Pierce Ave KKK da	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 303.9 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE ALCOHOLIC INTOXICATION FATTY METAMORPHOSIS OF LIVER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CERTIFICATION, REMOVAL (Specify)		24B. DATE 3/10/72	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR John E. Gable, Jr.	
25C. FUNERAL DIRECTOR H. J. G. Gable, Jr.		ADDRESS 635 N. G. / m. 82	

3-16-1972 - Letter - Office of the Chief Medical Examiner, Peter Lipkovic, M.D.
Assistant Medical Examiner

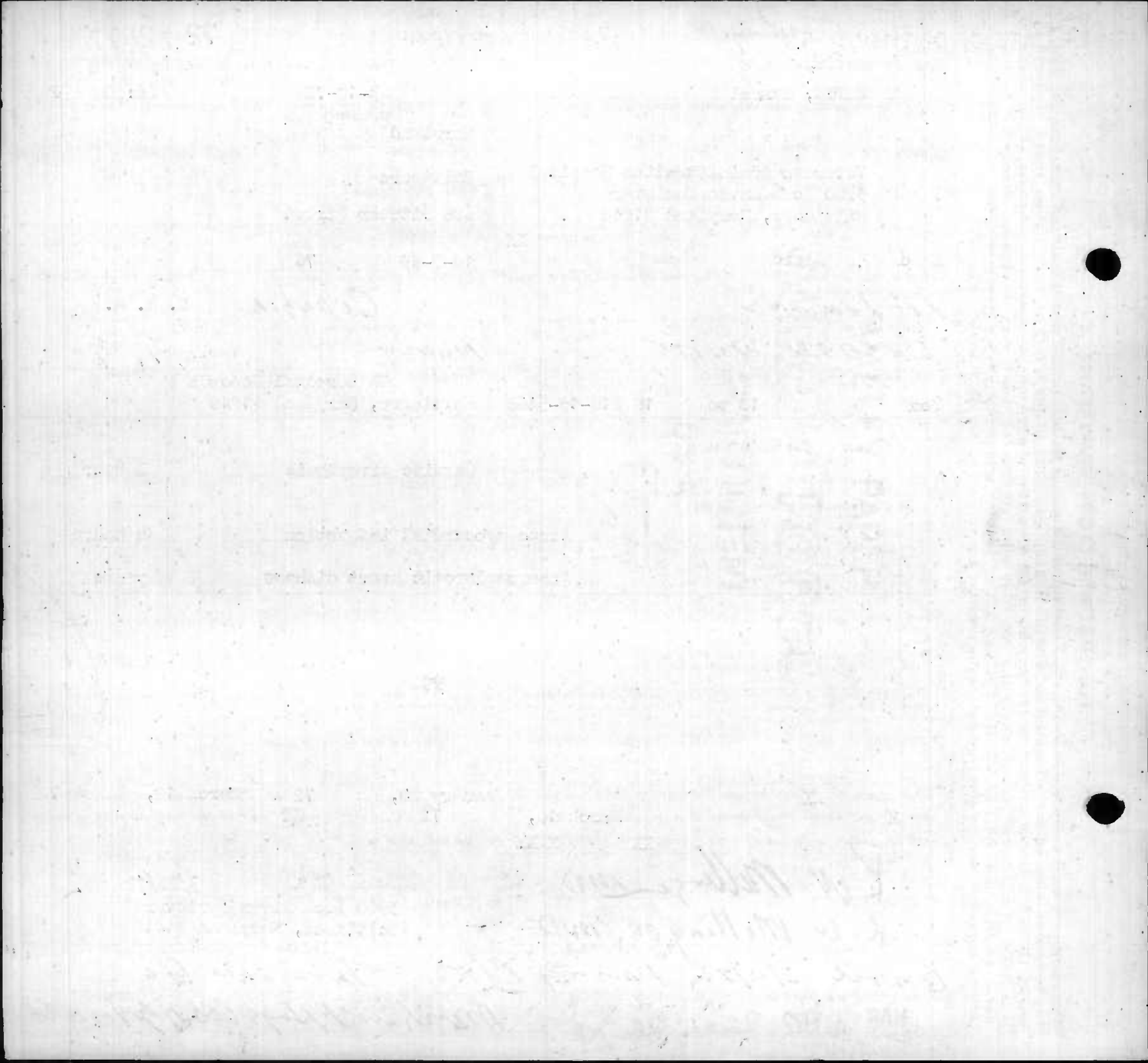
HRS

CERTIFICATE AMENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02577	
BIRTH NO. 72 02577				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>WHITE, Samuel</u>			2. DATE AND HOUR OF DEATH <u>3-10-72</u> <u>6:20</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1402</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>628 Pitcher Street</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-95</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>London White</u>		
14. MOTHER'S MAIDEN NAME <u>Nancy</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input type="checkbox"/> 18 to 18		
16. SOCIAL SECURITY NO. <u>218-18-5468</u>			17. INFORMANT <u>VA Hospital Records</u> ADDRESS <u>Baltimore, Maryland 21218</u>		
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Atherosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 hours</u> <u>years</u>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>January 20,</u> 19 <u>72</u> to <u>March 10,</u> 19 <u>72</u> , that <u>XX</u> (we) last saw the deceased alive on <u>March 10,</u> 19 <u>72</u> and that in <u>060</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>XX</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. W. Melling, M.D.</u>				23B. DATE SIGNED <u>3/14/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. W. Melling, M.D.</u>				23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>3/15/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Farmington</u>	
24D. LOCATION (City, town, or county) (State) <u>Thomson Ga</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>Blue E. Baker</u>		25C. FUNERAL DIRECTOR <u>APR 2 1972</u>	
ADDRESS <u>628 Pitcher St</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. Such

CERTIFICATE OF DEATH

REG. NO. 72-02578

BIRTH NO. 12-2018		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HOPKINS ORA B.		2. DATE AND HOUR OF DEATH MARCH 12, 1972 1:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL		4. USUAL RESIDENCE (Where deceased lived; If institutions residence before admission) A. STATE BALTIMORE, MD C. CITY OR TOWN BALTIMORE E. STREET AND NUMBER 2433 LINDEN AVE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-24-13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID		10B. KIND OF BUSINESS OR INDUSTRY NOTE CLUB	9. AGE (In years last birthday) 59
11. BIRTHPLACE (State or foreign country) SIGARLARK MISS		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME ZELIA ASH	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 12-2018	
17. INFORMANT ORA B. HOPKINS		ADDRESS 3622 DORIC RD	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized terminal stage II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown			
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from March 8 19 72 to March 12 19 72 that (I) (we) last saw the deceased alive on March 12 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M.P. COMBATIR		23B. DATE SIGNED U.D.	
23C. PHYSICIAN'S NAME (Type) M.P. COMBATIR		23D. ADDRESS PROVIDENT HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/72	
24C. NAME OF CEMETERY OR CREMATORY Maryland National		24D. LOCATION (City, town, or county) (State) MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR J. E. Jones	
25C. FUNERAL DIRECTOR St. John's Funeral Home		25D. ADDRESS 638 N. Gt. St.	

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

W. H. H. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

45-39-23 djr		Y-340		72 02579		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02579	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) VETTEL, NELLIE F				2. DATE AND HOUR OF DEATH 3/10/72 4:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO				5. CITY OR TOWN Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 4940 Eastern Avenue 21224			
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/7/88		9. AGE (In years last birthday) 83		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10B. KIND OF BUSINESS OR INDUSTRY Sewing				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Bowersox				14. MOTHER'S MAIDEN NAME Nellie Jones							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO. 218-05-1604		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 205/1 CAUSE OF DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO-RESPIRATORY ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CHRONIC MYELOGENOUS LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF: Aug 1967				years.			
(C) ASCVD, CVD											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Severe Anemia								2 mos			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 7/25 1968 to 3/10 1972 that (I) (we) last saw the deceased alive on 3/10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Karen T. O'Neill				23B. DATE SIGNED 3/10/72				23C. PHYSICIAN'S NAME (Type) Karen O'Neill			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-13-72		24C. NAME OF CEMETERY Loudon Park		24D. LOCATION (City, town, or county) (State) Balt. Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR William Cook-Brooks			

545 S. 45th St.

Adm. 7/15/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02580	
72 02580				CERTIFICATE OF DEATH	
BIRTH NO. <u>H-626</u>		1. NAME OF DECEASED (Type or Print) <u>Hirschhorn, Solomon</u>		2. DATE AND HOUR OF DEATH <u>3/12/72</u> <u>10:10 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u>		
			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3600 CLARINTH ROAD</u>		
5. SEX <u>MALE</u>	6. RACE <u>W HITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAW</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>	11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Hirschhorn</u>			14. MOTHER'S MAIDEN NAME <u>Jennie Goldenstein</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-38-9566</u>	17. INFORMANT <u>MR. EMANUEL HORN</u> ADDRESS <u>1704 CT. SQ. BLDG. #2</u>		
18. <u>153.81</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hydrothorax</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of colon</u> <u>lung metastasis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/29</u> 19 <u>72</u> to <u>3/12</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>3/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Veena Sathirakul M.D.</u>			23B. DATE SIGNED <u>3/12/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>VEENA SATHIRAKUL M.D.</u>			23D. ADDRESS <u>NORTH CHARLES GENERAL HOSP</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-13-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS.</u>	
ADDRESS <u>6010 REISTERSTOWN ROAD</u>					

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

1975-76

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02581</u>
M-220		72 02581		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Vera Moses</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>3-11-72</u> <u>4:40 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>27154 Hanson Ave #9</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21, 1903</u>	9. AGE (In years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland, xxxxxx</u>
13. FATHER'S NAME <u>Wolfe Friedman</u>		14. MOTHER'S MAIDEN NAME <u>DORA Kramer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-52-5693</u>		17. INFORMANT <u>MR. TOM MOSES, 27154 HANSON AVE. APT. 2C #9</u> <u>xxxxxxx</u>
18. <u>590.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal failure & Septicemia</u> <u>Chronic Pyelonephritis with acute exacerbation.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0 1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>3-2-72</u> 19 <u>72</u> to <u>3-11</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>3-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Pricha Phattiyakul, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> House Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-11-72</u>
23C. PHYSICIAN'S NAME (Type) <u>PRICHA PHATTIYAKUL, M.D.</u>		23D. ADDRESS <u>Sinai Hosp. of Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-13-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		
25B. NAME OF REGISTRAR <u>224832</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

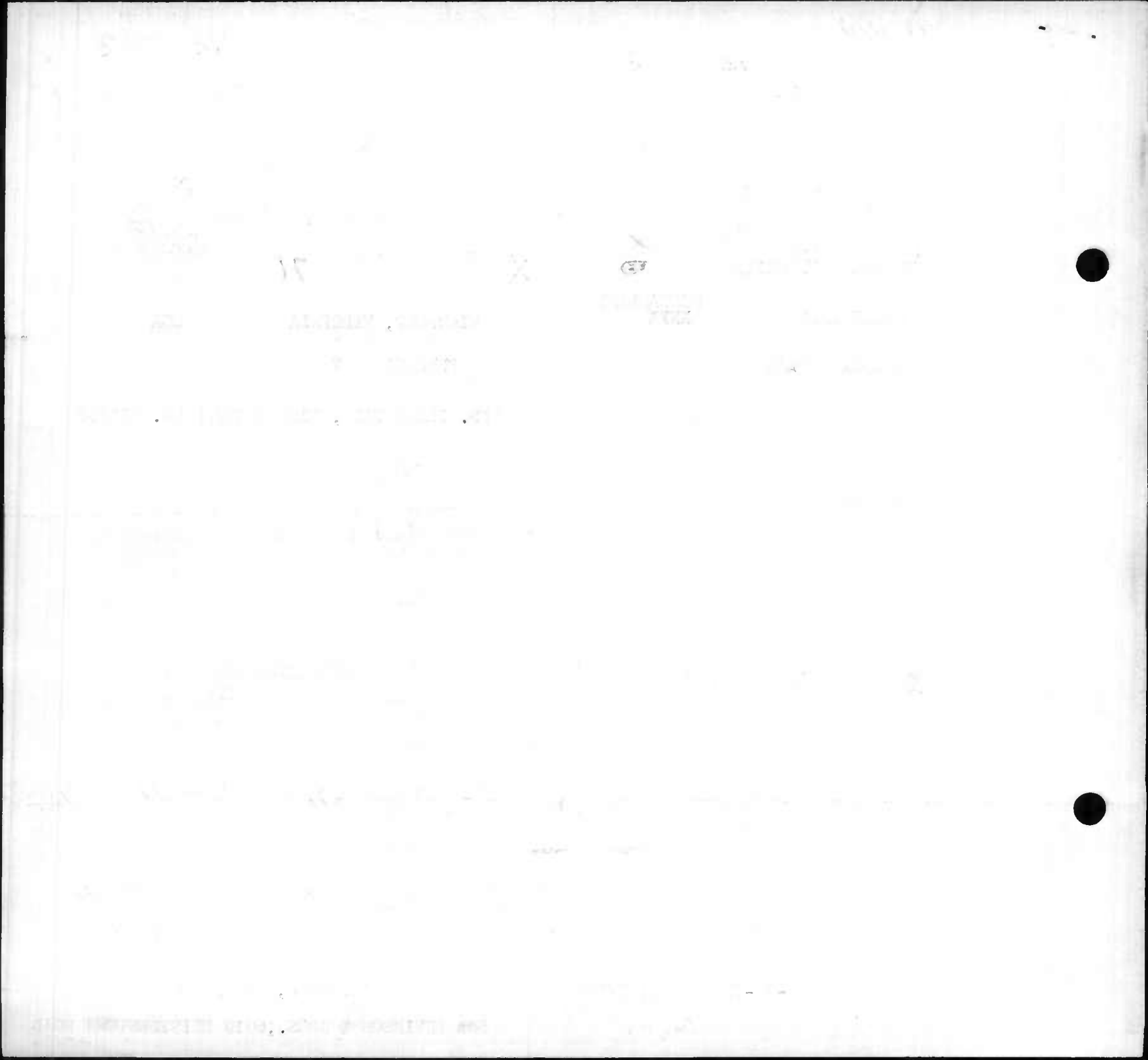
100-100000

100-100000

100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

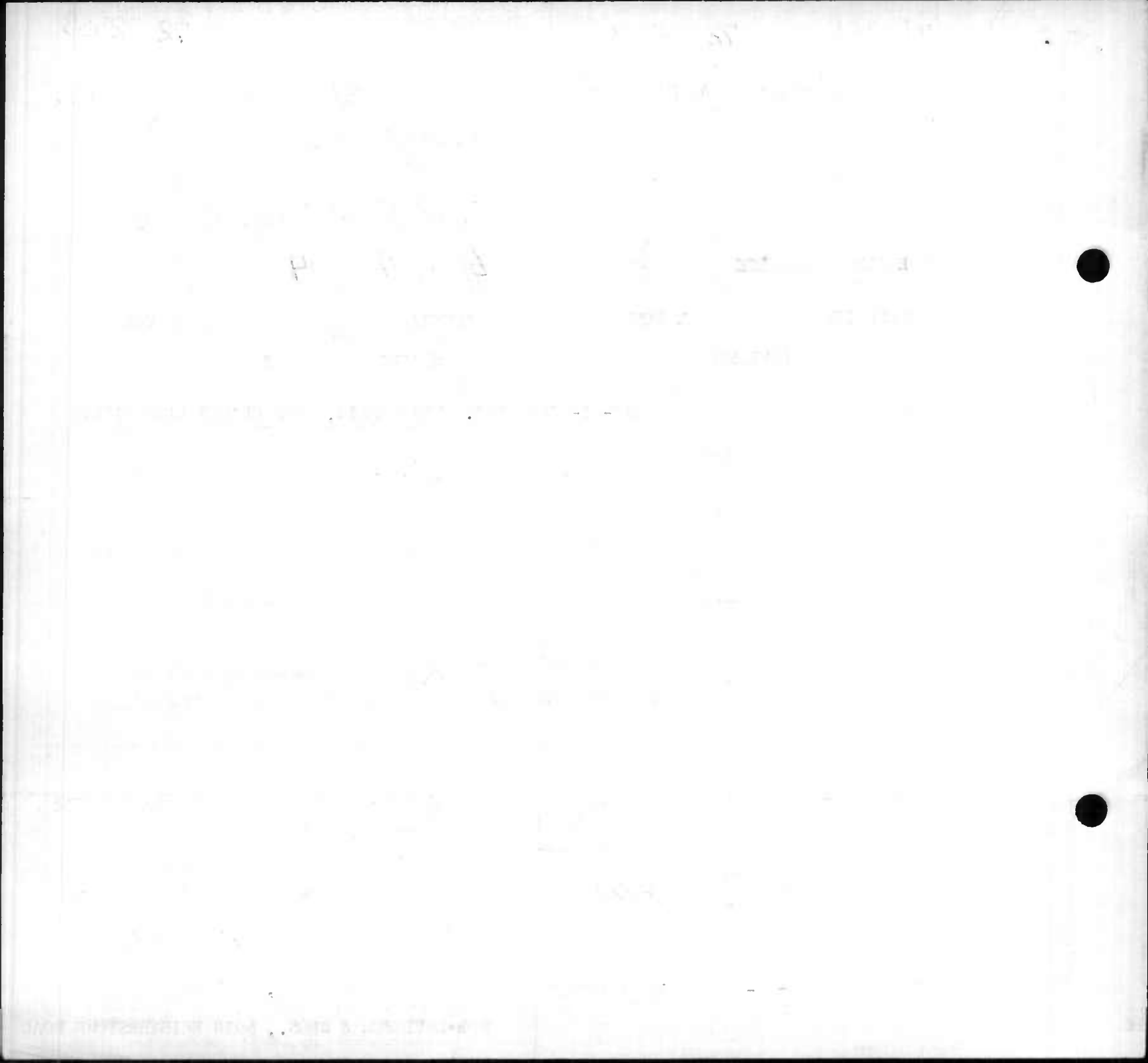
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02582	
BIRTH NO. W-410		72 02582					
1. NAME OF DECEASED (Type or Print) SADYE WOLFE				2. DATE AND HOUR OF DEATH 3-11-72 1 3:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1511			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3603 Fern Hill Ave #15			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-23-01	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) RICHMOND, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISRAEL CAPLAN				14. MOTHER'S MAIDEN NAME REBECCA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. ILENE TASK, 8260 BRATTLE RD. #21208			
18. 36211 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE SEP 813 DUE TO, OR AS A CONSEQUENCE OF: Diverticulitis & Abscess formation (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2-29-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diverticulitis & abscess		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-27-1972 to 3-11-1972 that (I) (we) last saw the deceased alive on 3-11-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Wiset Tangchai, M.D.				23B. DATE SIGNED 3-11-72		23C. PHYSICIAN'S NAME (Type) WISET TANGCHAI MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-12-72		24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR SOE LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

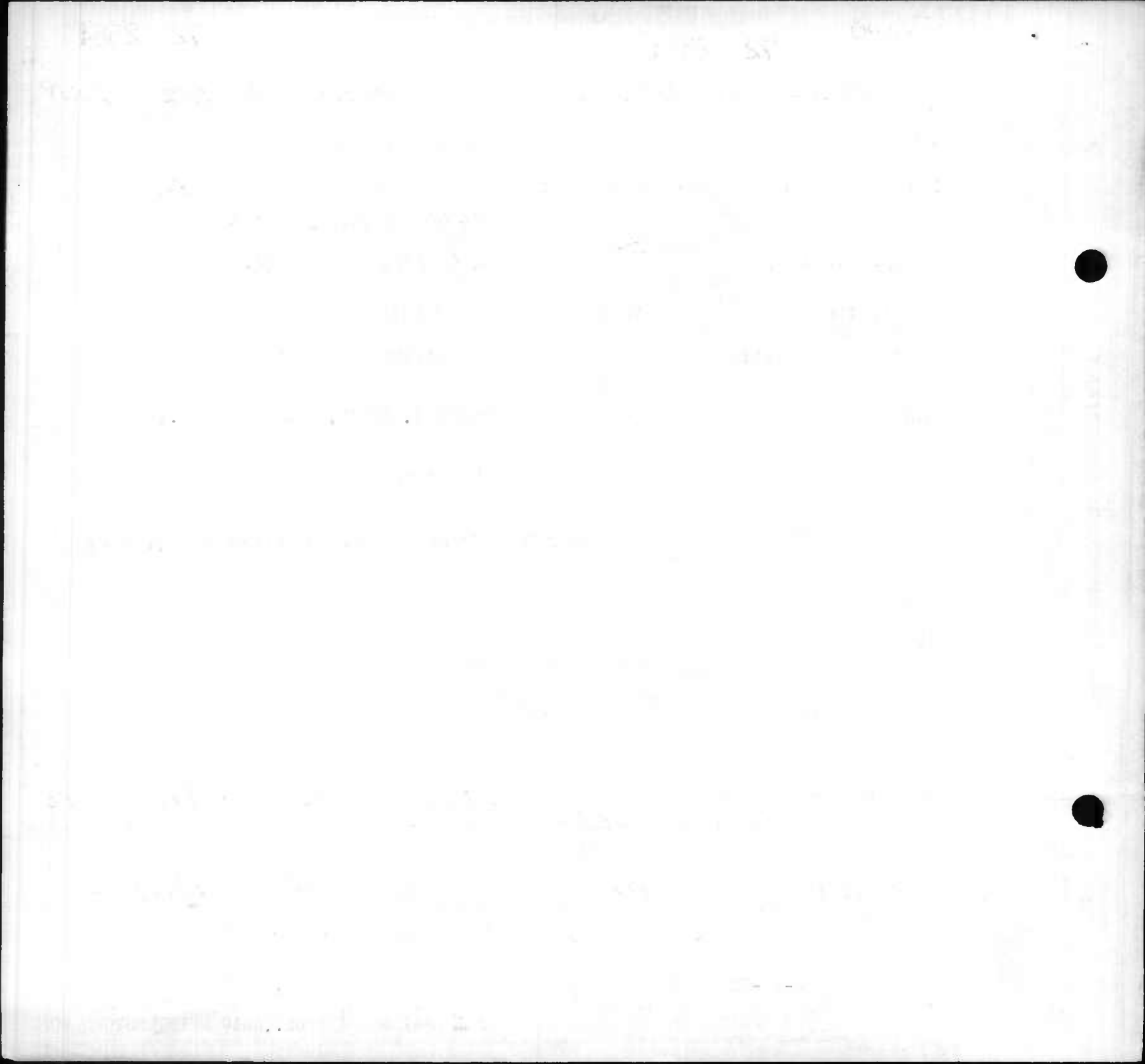
BALTIMORE CITY HEALTH DEPARTMENT		72 02583		72 02583	
BIRTH NO. <u>M-460</u>		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>ANNA MILLER</u>			2. DATE AND HOUR OF DEATH <u>3/10/72</u> <u>12:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6930 BROOKMILL RD</u> <u>21215</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/1911</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>LEVINSON</u>			14. MOTHER'S MAIDEN NAME <u>SHIFRA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-8386</u>		17. INFORMANT <u>MRS. MYRA HANKIN, 4008 CLARKS LANE #21215</u>	
18. <u>43691</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS.</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>4/13/72</u> 19 <u>72</u> to <u>3/10</u> 19 <u>72</u> that (U) (we) last saw the deceased alive on <u>3/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B KERNER MD</u> DEGREE			23B. DATE SIGNED <u>3/10/72</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>B KERNER MD</u> DEGREE			23D. ADDRESS <u>SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>3-12-72</u>	24C. NAME of CEMETERY or CREMATORY <u>ANSHE EMUNAH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot, R.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-600		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02584	
72 02584		CERTIFICATE OF DEATH		72 02584	
1. NAME OF DECEASED (Type or Print) <u>CELIA L. SHEAR</u>		2. DATE AND HOUR OF DEATH <u>MARCH 10th 1972 2.50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTIMORE INC.</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2788</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5414 JONQUIL AVE.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/199</u>	9. AGE (in years last birthday) <u>72</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>? LEVIN</u>			
14. MOTHER'S MAIDEN NAME <u>EVELYN ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MORTON I. SHEAR, 9020 BRUNO RD., #21133</u>			
18. <u>205.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>INTRACEREBRAL BLEED</u> HOURS DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ACUTE MYELO-MONOCYTIC LEUKEMIA</u> WEEKS DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>02/29</u> 19 <u>72</u> to <u>03/10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>03/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. Weinstein M.D.</u>		23B. DATE SIGNED <u>3/10/72</u>		23C. PHYSICIAN'S NAME (Type) <u>FRANKLIN WEINSTEIN MD</u>	
23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>3-12-72</u>		24C. NAME of CEMETERY or CREMATORY <u>MIKRO KODESH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>E. S. S. R. S.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the Chief Medical Examiner's Office. MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the Chief Medical Examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-230		72 02585		BALTIMORE CITY HEALTH DEPARTMENT		72 02585	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Dorothy Cassidey</u>				2. DATE AND HOUR OF DEATH <u>March 11, 1972</u> 1 <u>12</u> <u>50</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>				E. STREET AND NUMBER <u>1824 HOPE STREET</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-15-09</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>WALHAUPTER, WILLIAM</u>				14. MOTHER'S MAIDEN NAME <u>HUBER, BARBARA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-05-5690</u>		17. INFORMANT <u>Emma Cunningham (sister)</u>		ADDRESS <u>3203 Chesterfield Ave.</u>	
18. <u>796.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pseudomonas Pneumonia</u> (B) <u>Pseudomonas Sepsis</u> (C) <u>Chronic Mercurial Poisoning</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 wks</u> <u>1wk</u> <u>yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>Renal Tubular Failure</u>		<u>yrs</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 3</u> 19 <u>72</u> to <u>March 11</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>March 11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter Densen MD</u>				23B. DATE SIGNED <u>March 11, 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>Peter Densen</u>				23D. ADDRESS <u>601 N. Broadway</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/14/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR <u>Songmunk Funeral Homes, Inc.</u>		ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	

RECEIVED

RECEIVED

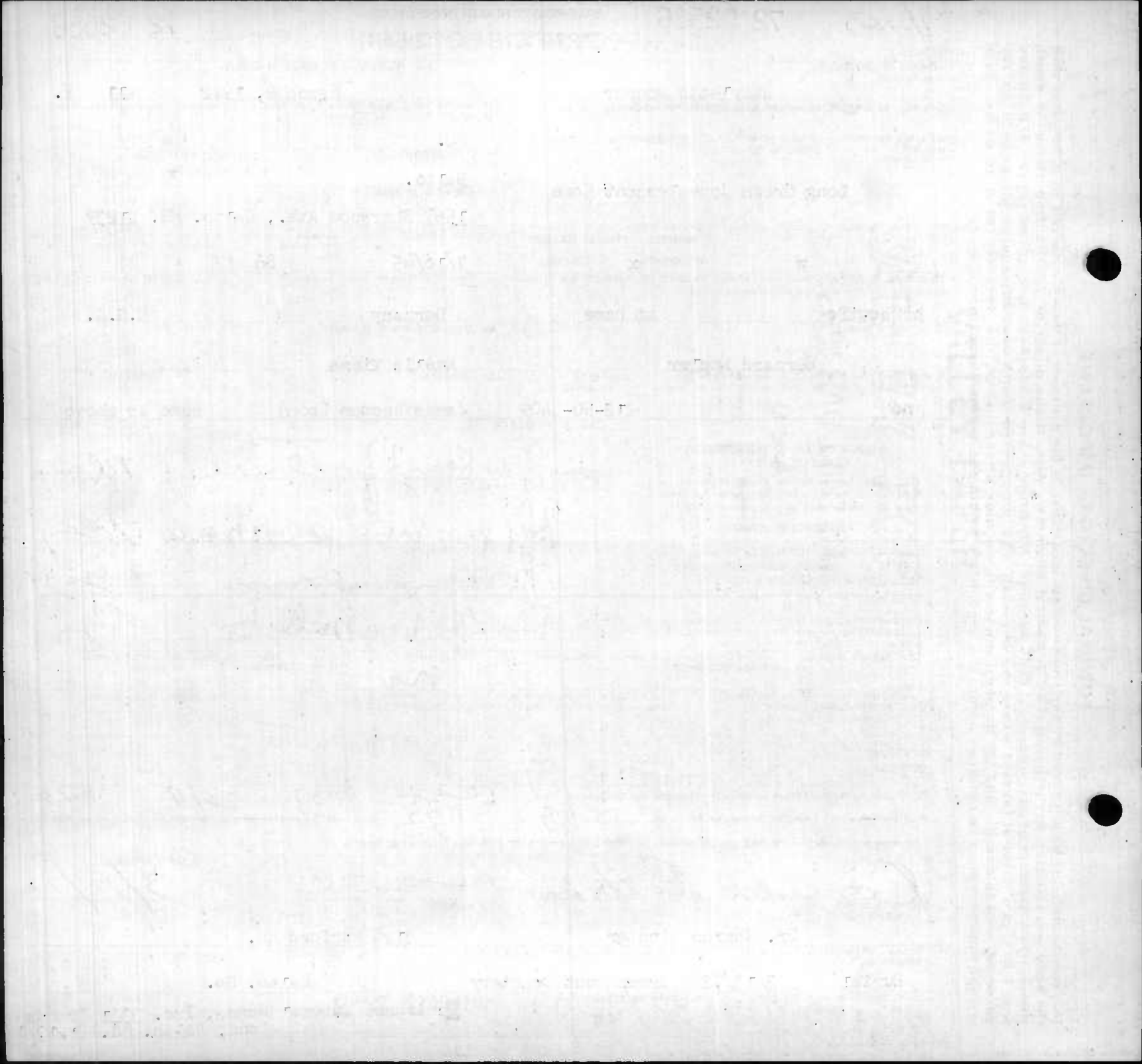
RECEIVED

1938-20-72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02586	
4-160 72 02586				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Charlotte Hooper			2. DATE AND HOUR OF DEATH March 9, 1972 11 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Convalescent Home			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. 8. COUNTY 2758 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1559 Sherwood Ave., Balto. Md. 21239		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/85	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Bernard Eppler			14. MOTHER'S MAIDEN NAME Amelia Tiema		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-50-4409	17. INFORMANT James Hooper (son) ADDRESS same as above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 440.91 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart failure 2 day (B) Myocardial infarction 4 day (C) Arteriosclerosis 2 yrs Diabetes mellitus 5 yr		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 19 47 to 3/9 1972, that (I) (we) last saw the deceased alive on 3/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Conrad Richter				23B. DATE SIGNED 3/11/72	
23C. PHYSICIAN'S NAME (Type) Dr. Conrad Richter				23D. ADDRESS 3128 Harford Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/72		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, Md.		25C. FUNERAL DIRECTOR Schlunke Funeral Homes, Inc.	
25D. ADDRESS 3331 Brehms Lane, Balto. Md. 21213					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-324		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02587	
1. NAME OF DECEASED (Type or Print) STIGLER, TERESA AGNES			2. DATE AND HOUR OF DEATH MARCH 12, 1972 3:40A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD COUNTY C. CITY OR TOWN ELLCOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3106 HAYFIELD DRIVE 21043		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-91	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOMEMAKER		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME JOHN D. MOONEY		
14. MOTHER'S MAIDEN NAME MARY SWEENEY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219543337			17. INFORMANT ADDRESS WILKENS AVE. BALTIMORE, MD. 21229 ST AGNES HOSPITAL RECORDS-CATON &		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 394.91 CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MITRAL STENOSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from FEBRUARY 25, 1972 to MARCH 12, 1972 that (X) (we) last saw the deceased alive on MARCH 12, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Lee M.D.			23B. DATE SIGNED March 12, 1972		
23C. PHYSICIAN'S NAME (Type) LEE, JOUNG SOON MD			23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Black Funeral Home Ellicott City, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Kelly, MD		25C. ADDRESS Black Funeral Home Ellicott City, Md.	

PROCESSED

2 . 250000 1000000

11-11-11

PROCESSED

11-11-11

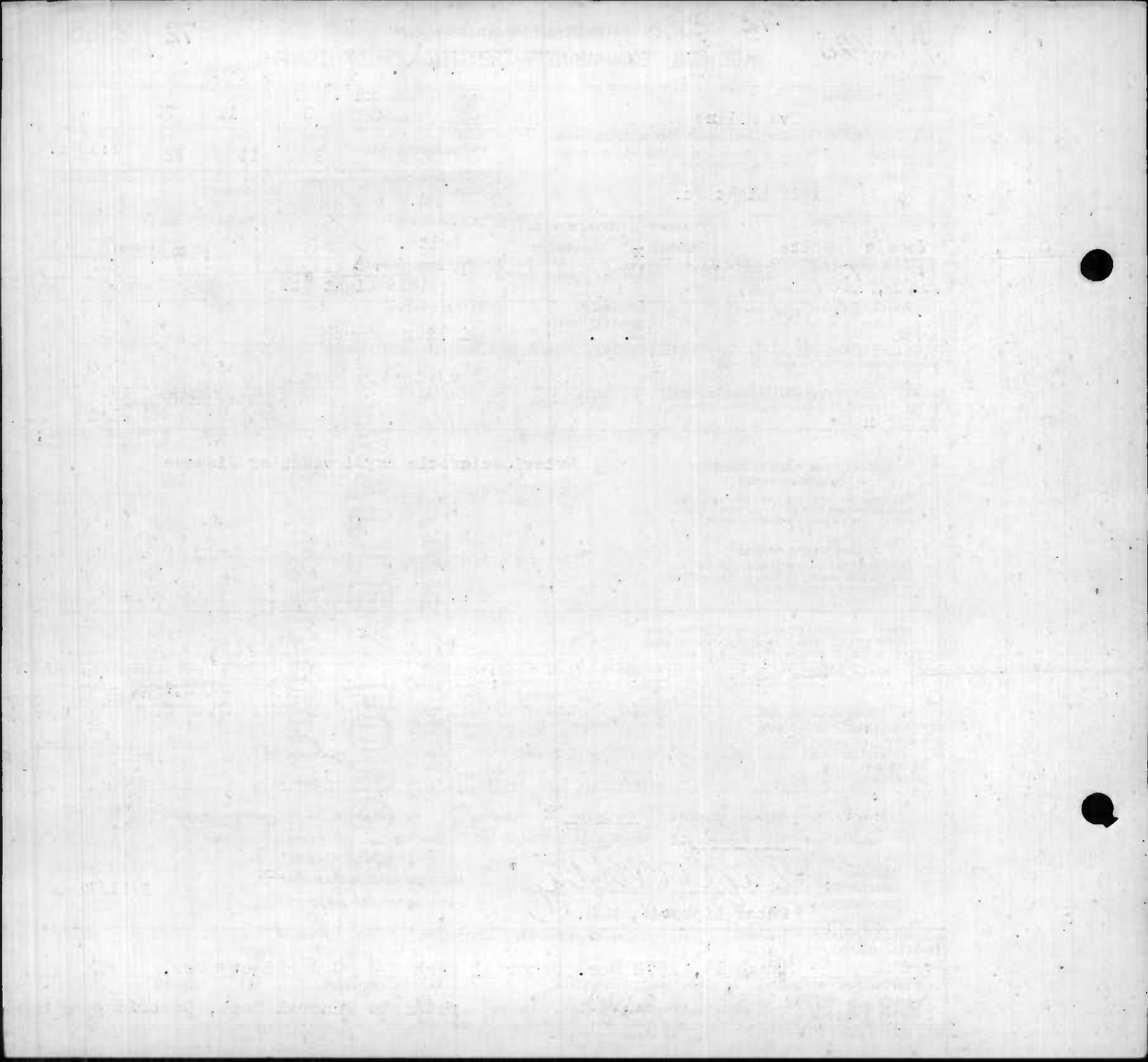
11-11-11

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eva Miller		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1829 Light St.		3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72		Hour 2:50 a.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2404		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1829 Light St.	
9. DATE OF BIRTH Dec. 16, 1884		10. AGE (In years last birthday) 87		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME William North		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
15. MOTHER'S MAIDEN NAME Lou Wingate North		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		17. SOCIAL SECURITY NO.	
18. INFORMANT William A. Todd		19. ADDRESS 506 Robbins Street Cambridge MD 21613		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 3/11/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 14, 1972		24C. NAME OF CEMETERY or CREMATORY Dor. Memorial Park	
24D. LOCATION (City, town, or county) (State) Cambridge Dor. MD		24E. FUNERAL DIRECTOR LeCompte Funeral Home, Cambridge MD		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR LeCompte Funeral Home, Cambridge MD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02589	
G-432 72 02589 CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) MYRLE GOLDSTEIN			
2. DATE AND HOUR OF DEATH 3/11/72		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER 3508 ESSEX ROAD		7. SEX F 8. RACE W 9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. DATE OF BIRTH 01-11-01		11. AGE (in years last birthday) 71			
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. FATHER'S NAME BRIGGS, OLIVER		15. MOTHER'S MAIDEN NAME GRIMES, ADDIE			
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 215-05-4272		18. INFORMANT David Goldstein ADDRESS 3508 Essex Rd. 21207	
19. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypoxia </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> (B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Interstitial Fibrosis </div> <div style="width: 35%;"> (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 03-09-72 19 03-11 19 72 that (2) (we) last saw the deceased alive on 03-11 19 72 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE M.D. Hollenberg				23B. DATE SIGNED 3/11/72	
23C. PHYSICIAN'S NAME (Type) M.D. HOLLENBERG, DPAAL				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-1972		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Wilkens Ave. Balto. Md.		25A. DATE REC'D. BY HEALTH DEPT. MAR 14 1972 25B. NAME OF REGISTRAR [Signature]			
25C. FUNERAL DIRECTOR Hubbard Funeral Home Inc.				ADDRESS Wilkens Ave. Md.	

THE NEW YORK PUBLIC LIBRARY
ASTOR LENOX TILDEN FOUNDATION
155 E. 42ND ST. NEW YORK 17, N.Y.

LIBRARY, NEW YORK

LIBRARY, NEW YORK

LIBRARY, NEW YORK

LIBRARY, NEW YORK

1. NAME OF DECEASED (Type or Print) Ernest Hawkins		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 11 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 820 Carroll St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 11 72 8:40 a. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2102			
6. SEX male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/29/ 1926		10. AGE (In years last birthday) 45	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Solomon Hawkins		14. MOTHER'S MAIDEN NAME Bessie Garrett	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/11/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Robert E. Kelly	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

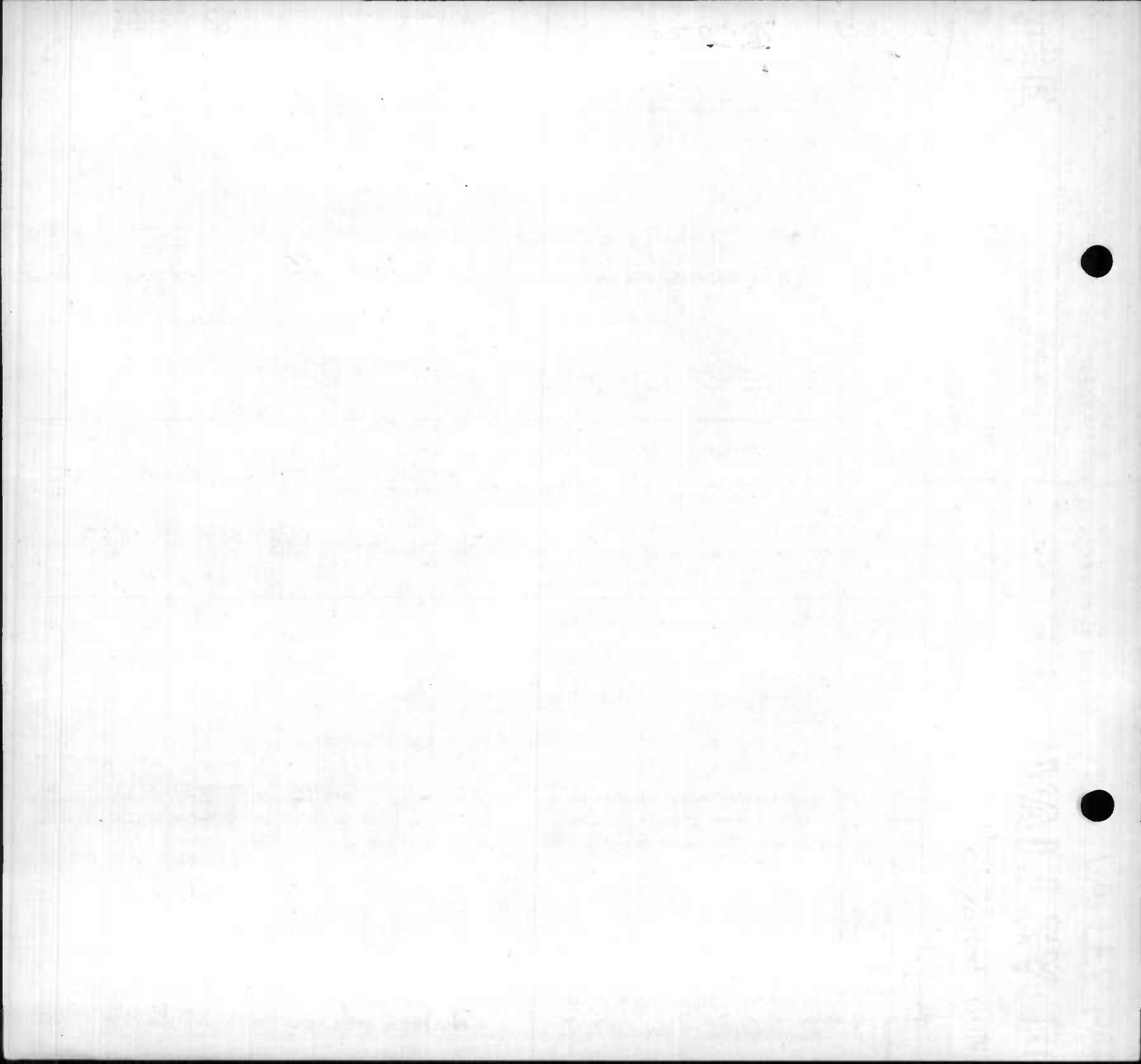
3/24/72 - Correction form from funeral director.

ABC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

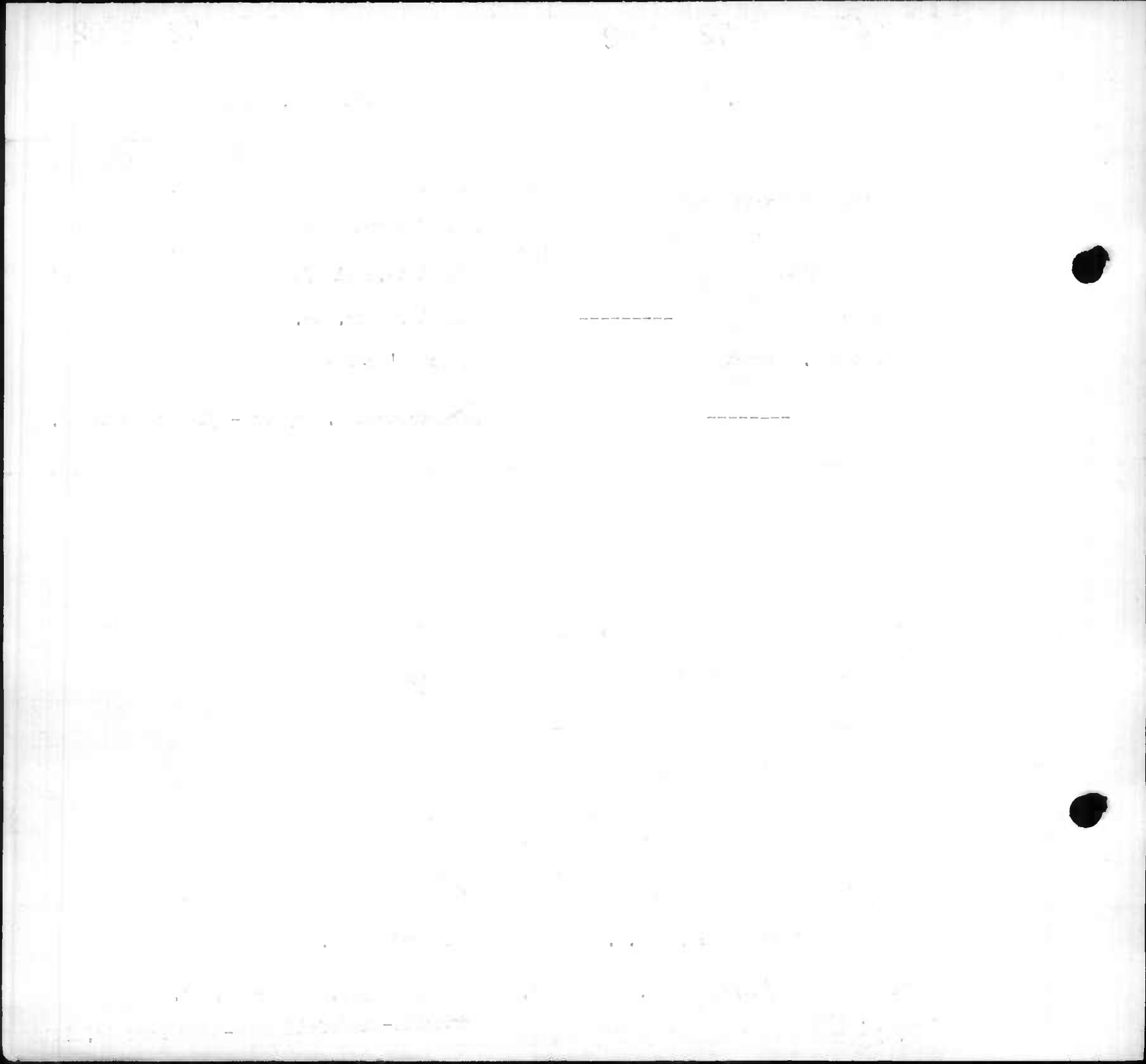
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02591	
L-200 72 02591				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) James R. Leach			
2. DATE AND HOUR OF DEATH 3-9-72 9¹⁶ A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 504 Wyeth St.		5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 5-26-1921 9. AGE (In years last birthday) 50		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE LEACH		14. MOTHER'S MAIDEN NAME ELIZABETH SIMMONS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ANNIE LEACH 504 WYETH ST.	
18. 410.9 + 1303.2		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable acute M.I.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Ischemic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: years.			
(C) _____					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-11 19 72 to 2-16 19 72 , that (I) (we) last saw the deceased alive on 2-16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert L. Muncie, Jr. MD				23B. DATE SIGNED 3-9-72	
23C. PHYSICIAN'S NAME (Type) Herbert L. MUNCIE, JR MD				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME OF CEMETERY or CREMATORY H. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972			
25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-263 BIRTH NO.		72 02592 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02592	
1. NAME OF DECEASED (Type or Print) A. NITA C. GUGERTY			2. DATE AND HOUR OF DEATH March 9th, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1529 Ralworth Road			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1529 Ralworth Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16th, 1891	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baldwin, Balto. Co.
13. FATHER'S NAME Peter J. Gugerty			14. MOTHER'S MAIDEN NAME Alice O'Rourke		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Miss Margaret M. Gugerty-1529 Ralworth Rd.
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Rheumatoid arthritis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 64 to March 19 1972 that (I) (we) last saw the deceased alive on Jan 25th 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Geo H. Beck			23B. DATE SIGNED 3/10/72		23C. PHYSICIAN'S NAME (Type) George Beck, M.D.
23D. ADDRESS 6012 Harford Rd.			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3/13/72		24C. NAME of CEMETERY or CREMATORY St. Johns Cem.		24D. LOCATION (City, town, or county) (State) Hyde, Long Green, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR Walter E. Fisher, R.A.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home-6500 York Rd. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

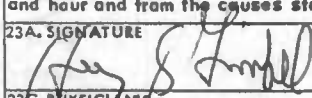
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02593
72 02593 CERTIFICATE OF DEATH		72 02593		
BIRTH NO. 1. NAME OF DECEASED (Type or Print) CATHERINE KAVANAUGH		2. DATE AND HOUR OF DEATH March 10, 1972 4:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3333 N. Charles St.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1202		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1895 9. AGE (In years last birthday) 76 If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY none		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Sachse		14. MOTHER'S MAIDEN NAME Sally -		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218 46 0673		17. INFORMANT Mr. Robert H. Kavanaugh ADDRESS 1915 Greenberry Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 15391 CAUSE OF DEATH Carcinomatosis, generalized (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) G. of bowel (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 yr.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 1972 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Aug 26 1971 to 3/10 1972 that (I) (we) last saw the deceased alive on 3/7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Norman R Freeman</i> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 3/10/72
23C. PHYSICIAN'S NAME (Type) NORMAN R FREEMAN, M.D.				23D. ADDRESS 11 W. 29th St, Baltimore, Md.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Frederick Rd Balto Md.		25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Mitchell Wiedefeld ADDRESS Home 6500 York Rd.		

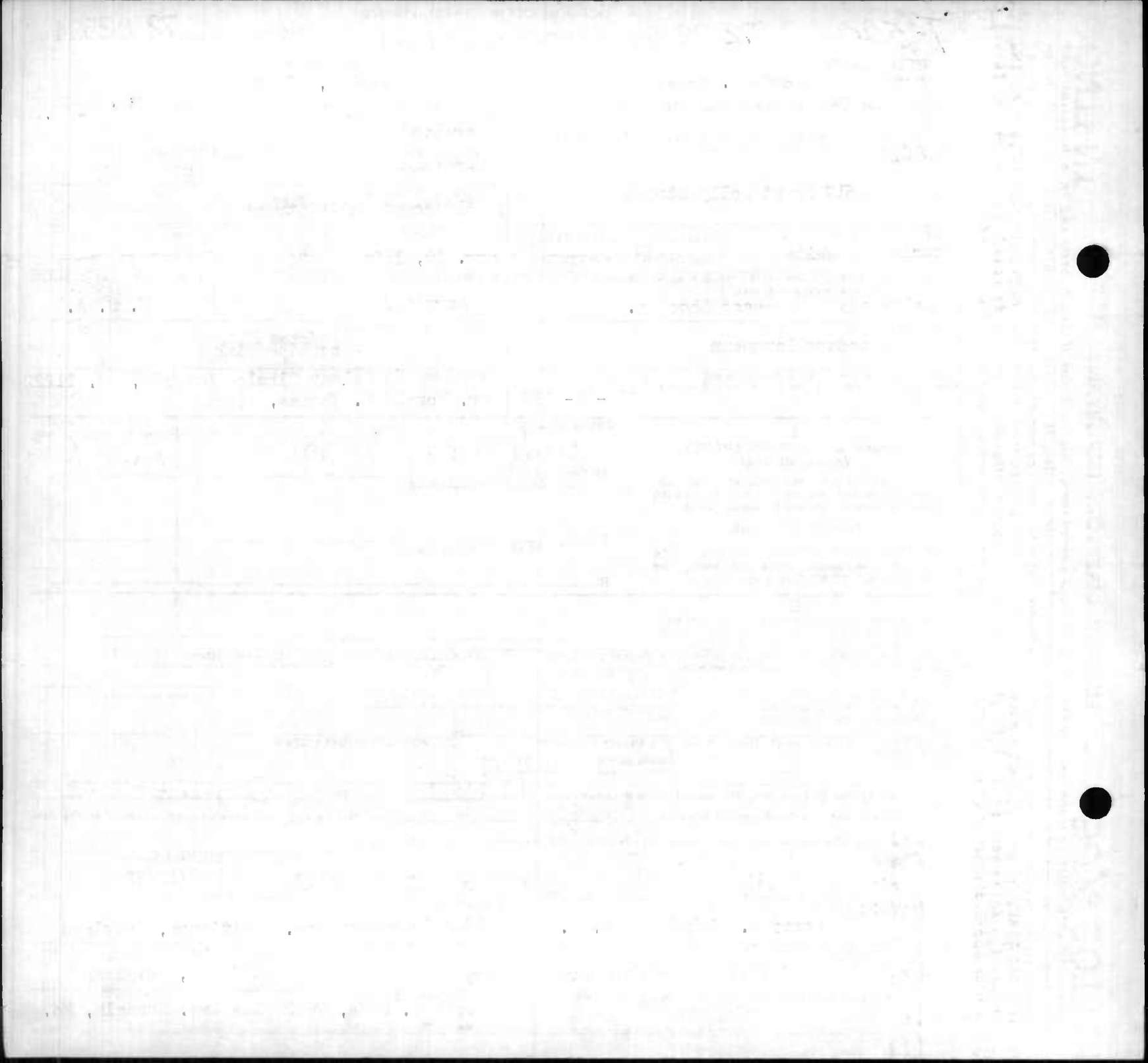
COPIES DESTROYED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

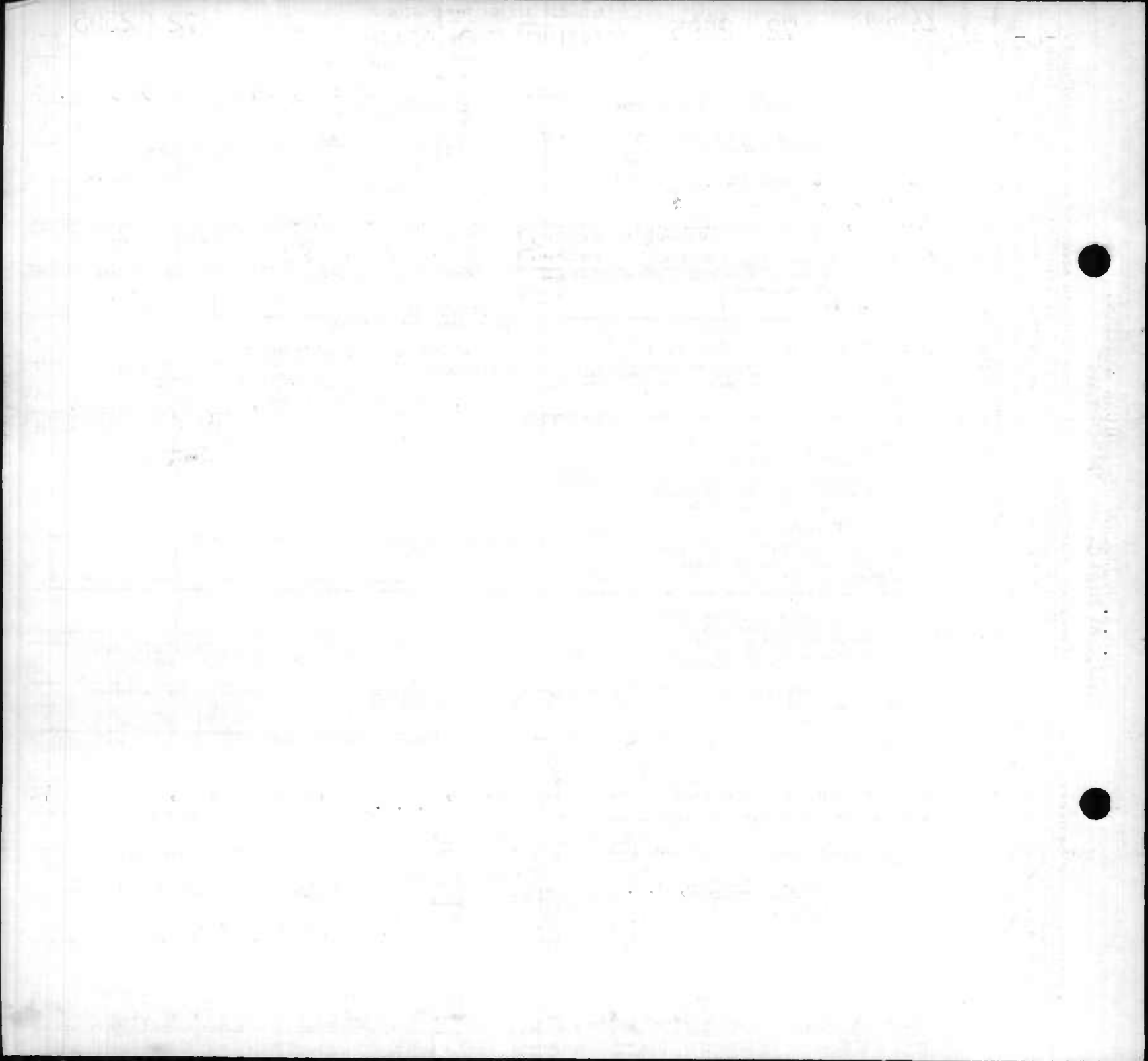
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02594</u>
T-520		72 02594		72 02594
BIRTH NO. <u>72 02594</u>				
1. NAME OF DECEASED (Type or Print) Marie H. Thomas			2. DATE AND HOUR OF DEATH March 9, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2037	
FULL NAME OF HOSPITAL OR INSTITUTION 00 517 Mount Holly Street			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 517 Mount Holly Street	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1895	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady Hess Shoe Co.			11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Theodore Fangmann			14. MOTHER'S MAIDEN NAME Josephine Fink	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-01-4199	
			17. INFORMANT 83 Delmar Circle Dundalk, Md. 21222 Mr. Donald H. Thomas, (Son)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Coronary Thrombosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
			(B) DUE TO, OR AS A CONSEQUENCE OF:	
			(C) DUE TO, OR AS A CONSEQUENCE OF:	
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1267 19 to 3-9-72 19 that (I) (we) last saw the deceased alive on 1-24-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 			23B. DATE SIGNED 3/10/72	
23C. PHYSICIAN'S NAME (Type) Harry S. Gimbel M. D.			23D. ADDRESS 4605 Edmondson Ave. Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/13/72		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.



D.O.A. RELEASED BY MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02595
BIRTH NO. H-200 72 02595		1. NAME OF DECEASED (Type or Print) Isabelle Hess		
2. DATE AND HOUR OF DEATH March 9, 1972 5:25 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN EASTPOINT D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
6. STREET AND NUMBER 818 Old North Point Road		7. SEX Female RACE Caucasian 8. DATE OF BIRTH 7/26/88 9. AGE (In years last birthday) 83		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		11. BIRTHPLACE (State or foreign country) Scotland 12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ARCHIBALD FORREST		14. MOTHER'S MAIDEN NAME ANNIE NAISMITH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		
17. INFORMANT BCH: RECORDS ADDRESS 4940 Eastern Avenue		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest - Heart block ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? Cerebral		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from March 9, 1972 to March 9, 1972 that (I) (we) last saw the deceased alive on 19 D.O.A. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Henry Ziegler, M.D. DEGREE		23B. DATE SIGNED March 9, 1972		23C. PHYSICIAN'S NAME (Type) G. J. ...
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 3/13/72 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN 24D. LOCATION (City, town, or county) (State) BALTO. MD.		
25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972		25B. NAME OF REGISTRAR J. G. CONNELLY		25C. FUNERAL DIRECTOR ADDRESS 300 MACE

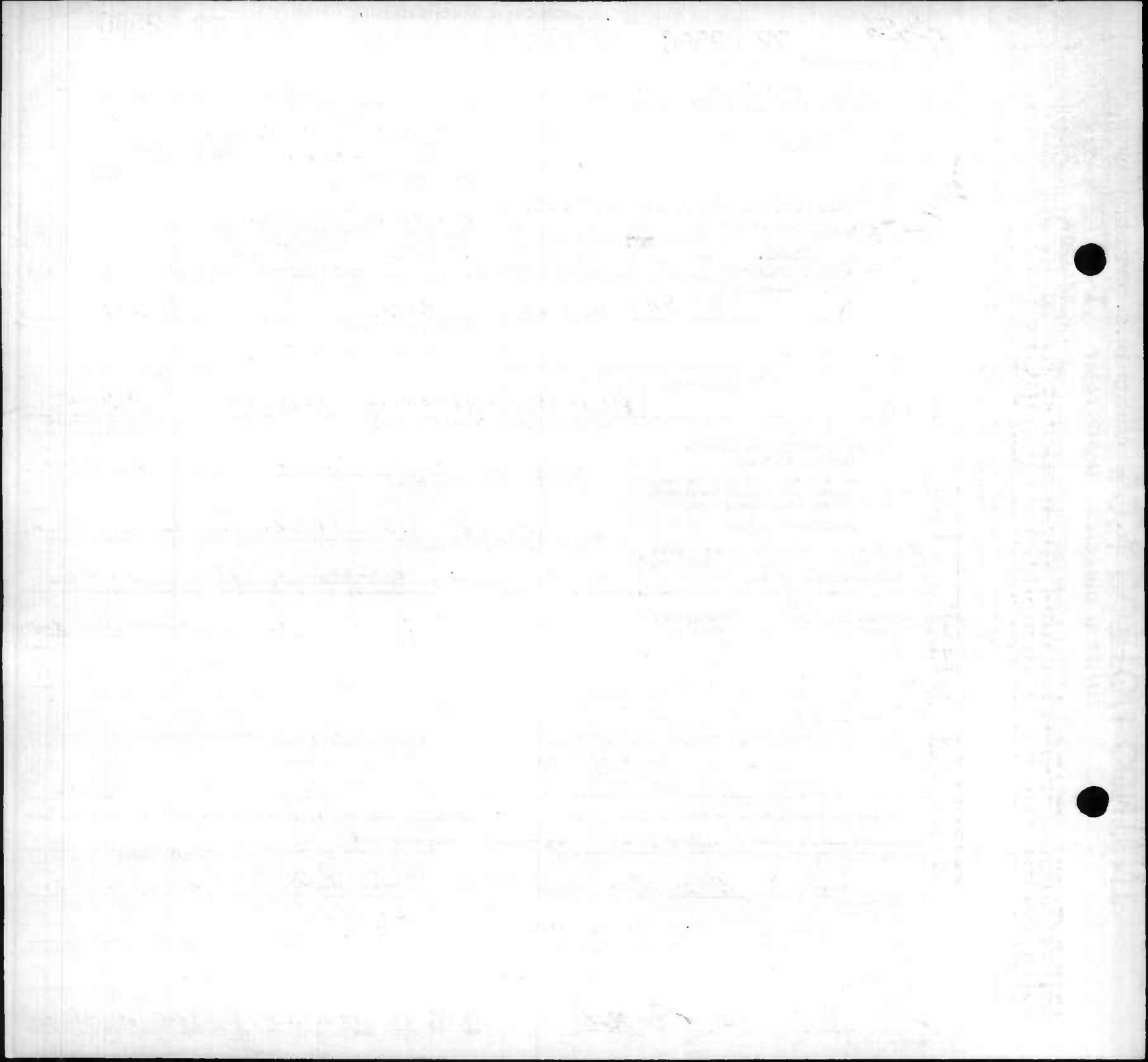


FUNERAL DIRECTOR: IMPORTANT

1 79 62 AS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

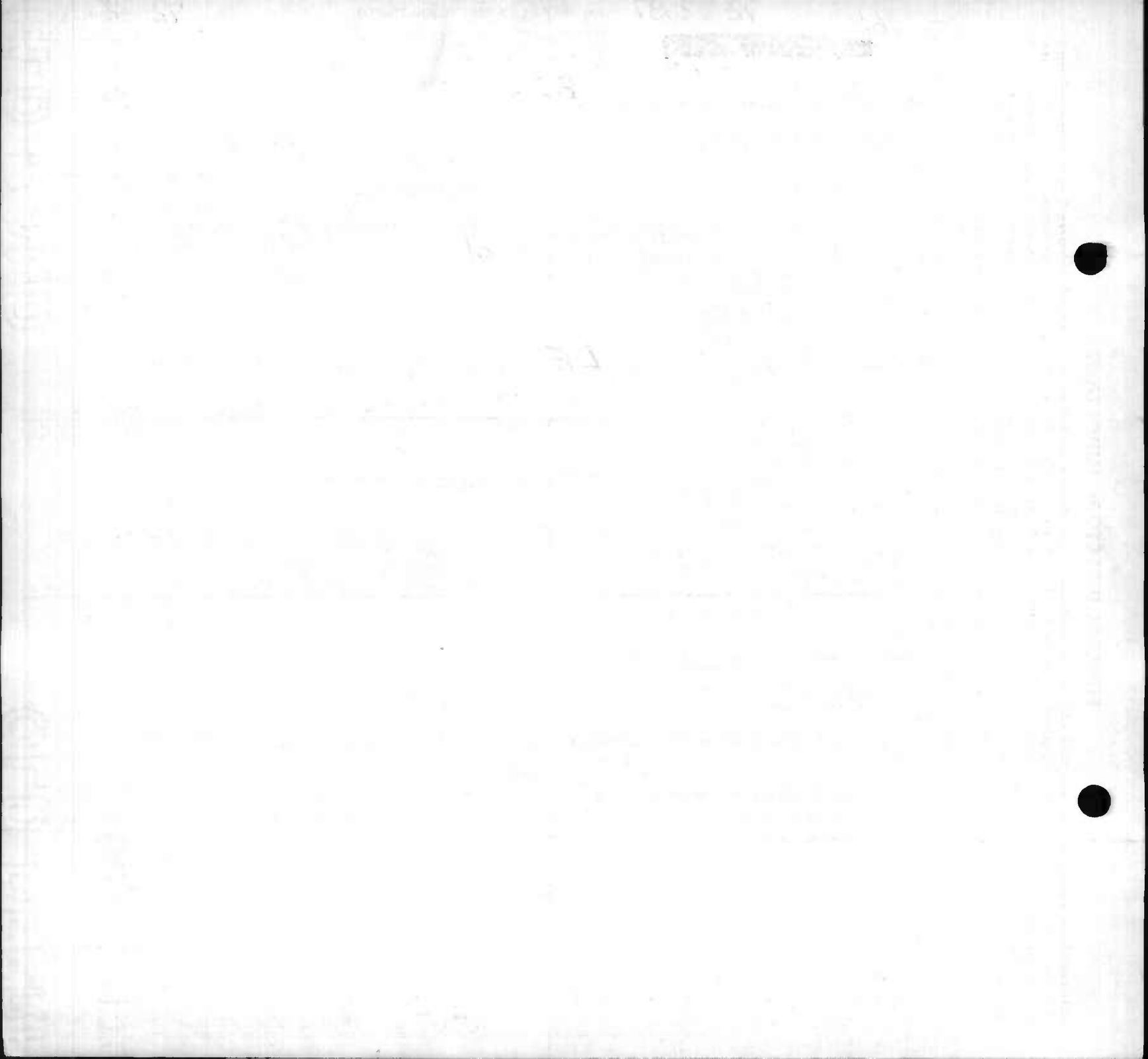
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02596	
K-456 72 02596		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Kellner, George J.		March 10, 1972 7 30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		A. STATE B. COUNTY Maryland Baltimore 5300			
5. SEX Male		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/12/21		9. AGE (in years last birthday) 50		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY SHIP BUILDER		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Perce Kellner		14. MOTHER'S MAIDEN NAME Madeline Dorn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 218-14-5852		17. INFORMANT CATHERINE KELLNER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.31		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic Shock		60 hours	
		(B) DUE TO, OR AS A CONSEQUENCE OF: multiple abdominal abscesses & empyema 3 weeks			
		(C) DUE TO, OR AS A CONSEQUENCE OF: anastomotic breakdown of colon		3 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		acute renal failure, depressed bone marrow 2 weeks			
19A. DATE OF OPERATION Feb 8, 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED sigmoid Cancer		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from Feb 26 1972 to March 10 1972 that (1) (yes) last saw the deceased alive on March 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jay E. Menitove, MD		23B. DATE SIGNED March 10, 1972		23C. PHYSICIAN'S NAME (Type) JAY E. MENITOVE, MD	
23D. ADDRESS Johns Hopkins Hospital Baltimore, MD		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/13/72	
24C. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. MAR 14 1972	
25B. NAME OF REGISTRAR JOHN J. COONEY		25C. FUNERAL DIRECTOR J. J. COONEY		25D. ADDRESS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

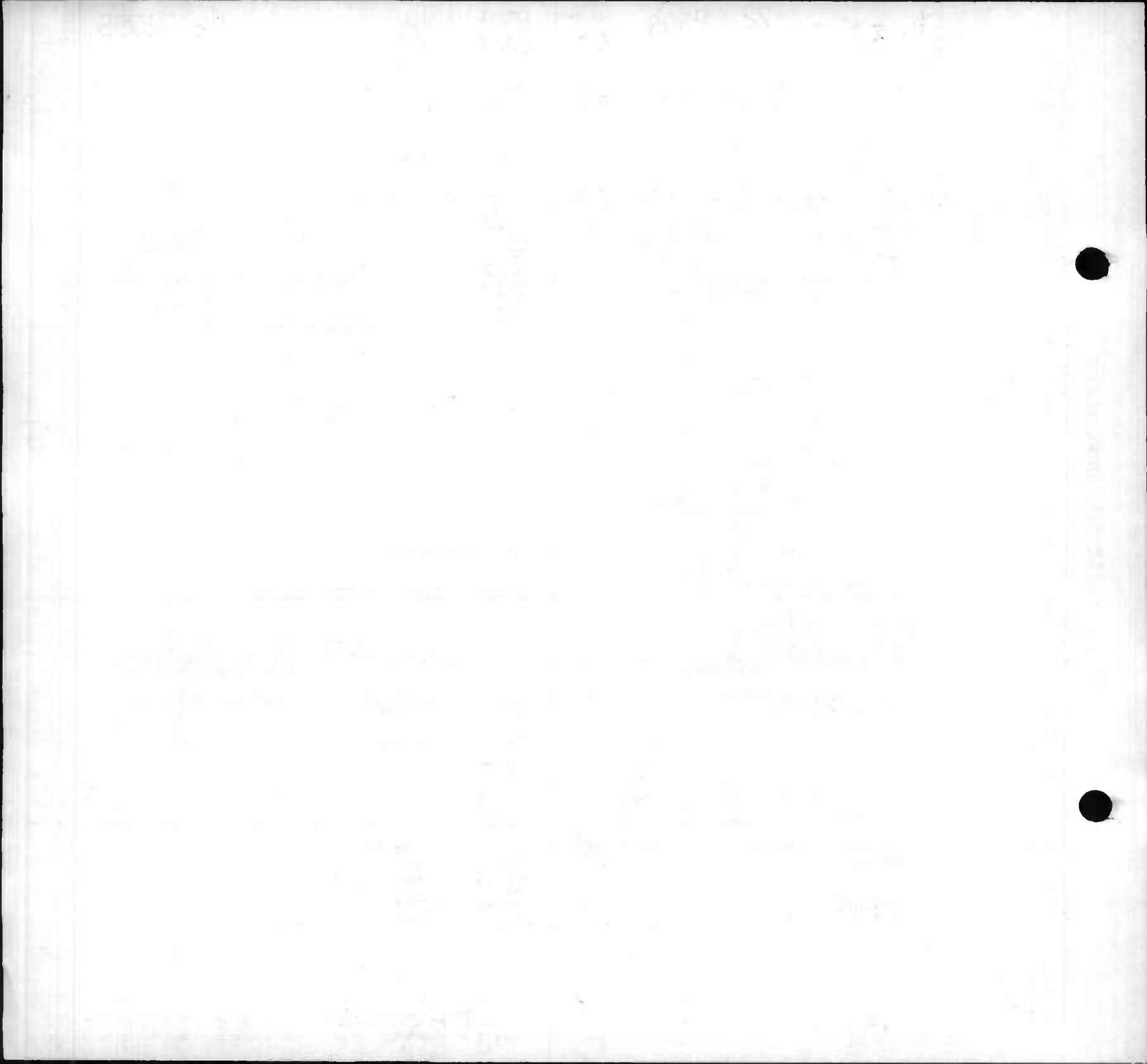
S-361		72 02597		BALTIMORE CITY HEALTH DEPARTMENT		72 02597	
CERTIFICATE OF DEATH				REG. NO. X			
1. NAME OF DECEASED (Type or Print)		EDGAR STRUBEL SR.		2. DATE AND HOUR OF DEATH		3/9/72 4:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE		B. COUNTY	
CHURCH HOME + HOSP.				MD		BALTO.	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/19/08	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STEEL WORKER						PA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ALLEN STRUBEL				SAVILLA PIERCE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
?				201018024		HELEN STRUBEL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2-3 y.	
ANTECEDENT CAUSES				(B) Most likely metastatic		2-3 wks.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) eucerebrovascular			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At <input type="checkbox"/>					
		Work <input type="checkbox"/> At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 2/4 1972 to 3/9 1972 that (I) (we) last saw the deceased alive on 3/9 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Dietrich V. Feldmann						3/9/72	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
DIETRICH V. FELDHAUEN							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		3/13/72		OAK LAWN		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 14 1972		Robert E. Kelly, Jr.		J.G. CONNELLY		300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02598	
BIRTH NO. 72 02598					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ANNIE (ANNABELL) JOHNSON			3-13-72 5.20 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE MARYLAND		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			B. COUNTY 1203		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 2404 GUILFORD AVE					
5. SEX F	6. RACE W N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1919	9. AGE (In years last birthday) 52	If Under 1 Tr. Months; Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			11. BIRTHPLACE (State or foreign country) VA		12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME JOHN MORRIS			14. MOTHER'S MAIDEN NAME SARAH BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-28-6247		17. INFORMANT ETTA COLBERT
			ADDRESS SAHE		
18. 4-27-72 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coroniac arrest			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-12-72 to 3-13-72 that (I) (we) last saw the deceased alive on 3-13-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan M. Calderon				23B. DATE SIGNED 3-13-72	
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON				23D. ADDRESS UMH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-72		24C. NAME OF CEMETERY or CREMATORY Mt AUBURN CEM.	
24D. LOCATION (City, town, or county) (State) BALTO. MD					
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robt S. ...		25C. FUNERAL DIRECTOR WMC MARCH	
		ADDRESS 928 E NORTH AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 02599</u>	
T-552 <u>72 02599</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>THOMAS TIMMONS</u>		2. DATE AND HOUR OF DEATH <u>3-12-72</u> <u>1:20</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1204</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2233 N. CALVERT STREET</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-05-09</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>62</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>ERIAN TIMMONS</u>		14. MOTHER'S MAIDEN NAME <u>ETTA WILLIAMS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>LAURA STANCIEL</u> ADDRESS <u>SAME</u>
18. <u>011.9</u> I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>RENAL INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>PROBABLE TBC</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> 19 <u>72</u> to <u>3-12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3-12</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Juan M. Calderon</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>3-12-72</u>
23C. PHYSICIAN'S NAME (Type) <u>JUAN M. CALDERON</u>		23D. ADDRESS <u>UMH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burned</u>	24B. DATE <u>3-15-72</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Botts Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1972</u>	25B. NAME OF REGISTRAR <u>Robt E. Taylor, Jr.</u>	25C. FUNERAL DIRECTOR <u>WM C NARCH</u> ADDRESS <u>928 E NORTH AVE</u>	

UNITED STATES DEPARTMENT OF THE ARMY

52

W

M

UNITED STATES DEPARTMENT OF THE ARMY

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

L-200

72 02600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02600

BIRTH NO.

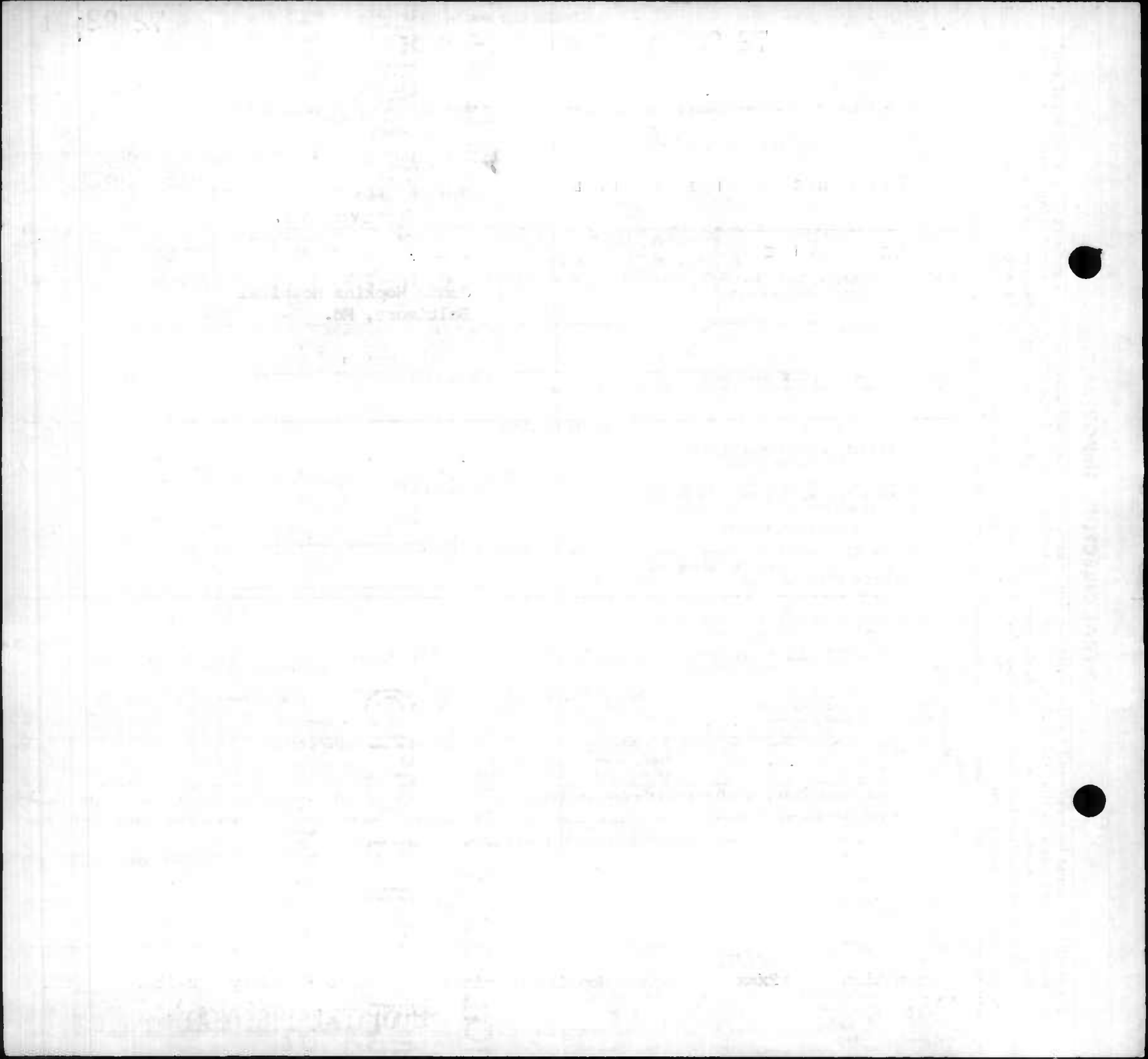
1. NAME OF DECEASED (Type or Print) REBECCA LAKE (Wright)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3411 Piedmont Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour March 8, 1972 10:00A M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/13/13		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) Uniontown, Ala		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		14B. KIND OF BUSINESS OR INDUSTRY Church	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 214-12-8929	
18. INFORMANT R ^u v Mrs Bessie Ralph, 4029 Anellen		ADDRESS 4029 Anellen	
19. 4/12/72 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Rheumatoid Arthritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/8/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/72	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Bea... ..	
25C. FUNERAL DIRECTOR Solphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

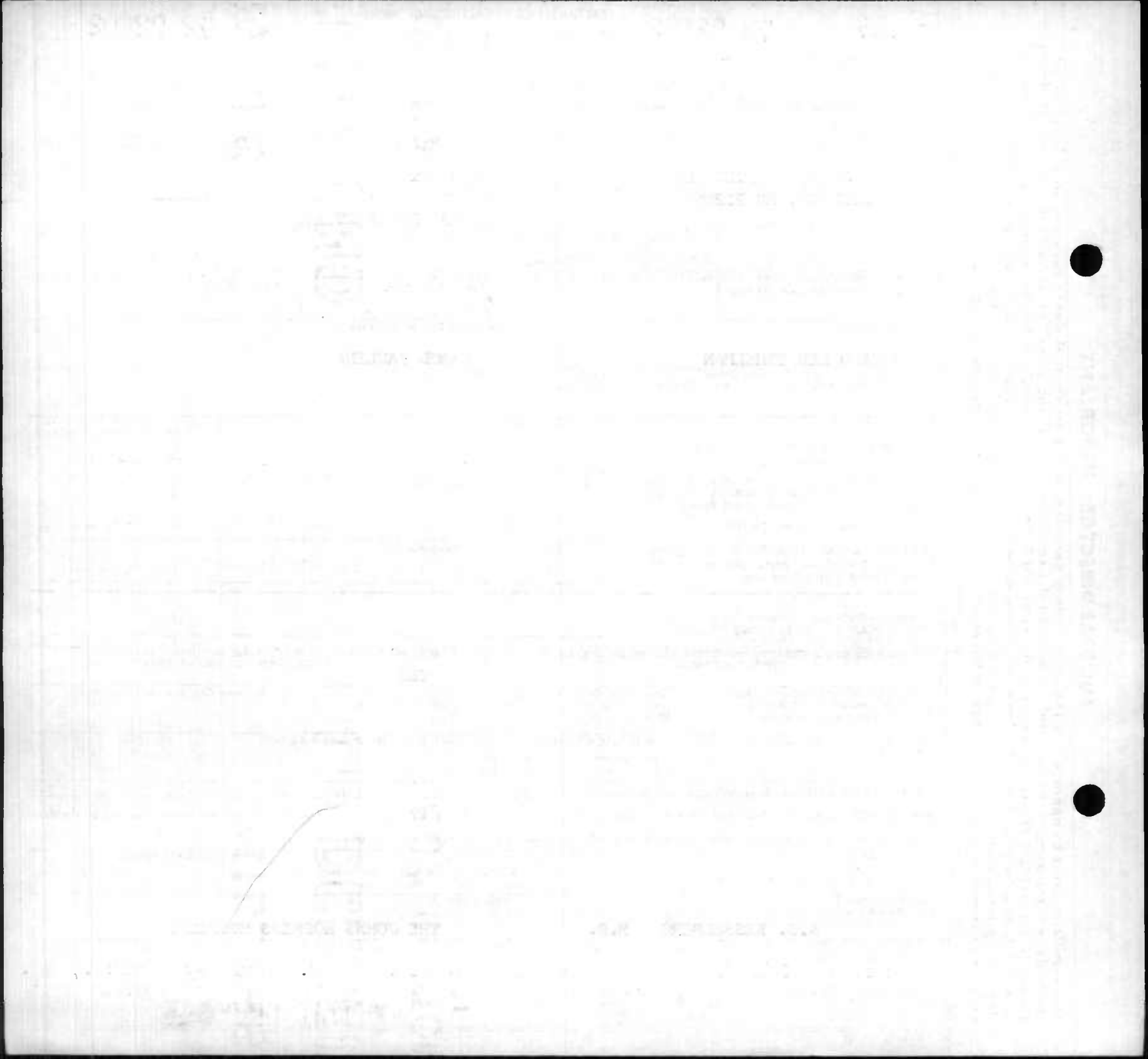
BALTIMORE CITY HEALTH DEPARTMENT				72 02601	
P-360				72 02601	
BIRTH NO. 72-03981				72 02601	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Potter B.B. BABY Boy				3/6/72 1:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				MARYLAND	
33				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				2215 ROSLYN AVE.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-6-72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Johns Hopkins Hospital Baltimore, Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
			BOEHMLEIN, EVA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 3/6 1972 to 3/6 1972 that (1) (we) last saw the deceased alive on 3/6 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
K. Teets M.D.				3/6/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
K. Teets				Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		3/11/72		Johns Hopkins Hospital	
				601 N Broadway Balto., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 15 1972		Robert E. Jellison, Jr.		HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02602	
<div style="display: flex; justify-content: space-between;"> E-244 72 02602 CERTIFICATE OF DEATH </div>					
BIRTH NO. <u>Hagerstown, Md.</u> 1. NAME OF DECEASED (Type or Print) <u>Eshelman, Baby Girl</u>			2. DATE AND HOUR OF DEATH <u>March 12, 1972</u> <u>12:55</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>BALTIMORE, MD 21205</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>WASHINGTON</u> C. CITY OR TOWN <u>HAGERSTOWN</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>238 PROSPECT AVE</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1972</u>		9. AGE (In years last birthday) <u>0</u> <u>4</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington County Hospital</u> <u>Hagerstown, MD</u>	
13. FATHER'S NAME <u>RONALD LEE ESHELMAN</u>			14. MOTHER'S MAIDEN NAME <u>CAROL PAULINE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ADDRESS</u>	
18. CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
			(B) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>24 hours</u>
			(C) <u>Hypoplastic Left Heart</u>		<u>4 days</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 11, 1972</u> to <u>March 12, 1972</u> that (I) (we) last saw the deceased alive on <u>March 12, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. G. Kesselberg MD</u>				23B. DATE SIGNED <u>March 12, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>A.G. KESSELBERG M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>3/12/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins Hospital</u>	
		24D. LOCATION (City, town, or county) (State) <u>601 N. Broadway Balto., Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, M.D.</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	



CERTIFICATE OF DEATH

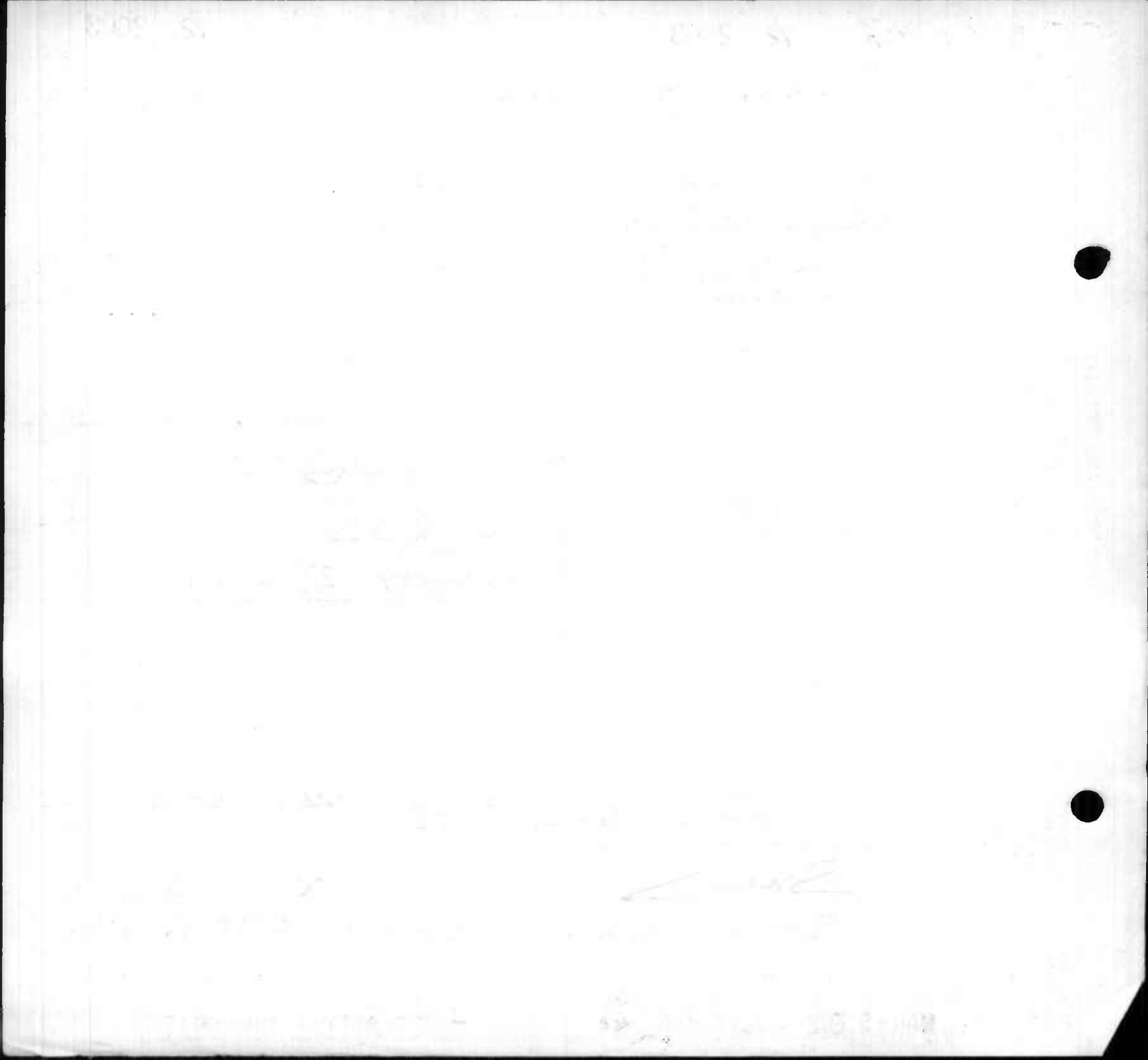
REG. NO.

72 02603

BIRTH NO. <i>K-456</i> <i>72 02603</i>		2. DATE AND HOUR OF DEATH <i>3-4-1972</i> <i>6.10 A.M.</i>	
1. NAME OF DECEASED (Type or Print) <i>Balto Co. Md.</i> <i>BABY BOY</i> <i>Kellner, BB Mary E (DiMattei)</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>BALTO</i> <i>5300</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3-3-72</i>		9. AGE (In years last birthday) <i>11</i> <i>25</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Kellner</i>		14. MOTHER'S MAIDEN NAME <i>Mary E DiMattei</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>BCH Records</i>		ADDRESS <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>	
18. <i>726.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-Respiratory Failure</i> (B) <i>Severe RDS</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Prematurity 28 weeks</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>None</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Approx. 11 hrs</i>	
19A. DATE OF OPERATION <i>3-4-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>RDS</i>	
20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-3-1972</i> to <i>3-4-1972</i> that (I) (we) last saw the deceased alive on <i>3-4-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Smeenk</i>		23B. DATE SIGNED <i>3-4-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>SMEENK, G.W.L.</i>		23D. ADDRESS <i>Balto. City Hospitals</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>3-6-72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore City Hospitals</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1972</i>		25B. NAME OF REGISTRAR <i>John E. Kelly, M.D.</i>	
25C. FUNERAL DIRECTOR		ADDRESS	
HOSPITAL DISPOSAL			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02604	
W-425		72 02604		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		James Wilson		03/09/72 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 The Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore, Maryland 21239			A. STATE Md. Baltimore City 1603		
			C. CITY OR TOWN Baltimore		
5. SEX M			6. RACE B		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 04 - 07 - 04		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10B. KIND OF BUSINESS OR INDUSTRY Unknown		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 055-01-9025		
17. INFORMANT Mrs. Wilhelmina Gerrel Wilmington, Del			ADDRESS		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Prostate (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 6 MONTHS (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION			20A. AUTOPSY? (Yes or No) No		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.)			21F. HOW DID INJURY OCCUR?		
22. I certify that (H) (this hospital) attended the deceased from 8 February 1972 to 9 March 1972 that (H) (we) last saw the deceased alive on 9 March 1972 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Colvin, MD			23B. DATE SIGNED 9 March 72		
23C. PHYSICIAN'S NAME (Type) MICHAEL COLVIN, MD			23D. ADDRESS Good Samaritan Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-72		24C. NAME of CEMETERY or CREMATORY Silverbrook Cemetery	
24D. LOCATION Wilmington		24E. CITY, town, or county Delaware		24F. STATE Delaware	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Forrest Jolly Jr., R.D. Salisbury, Md.	

12/24/71
1601 W. Lanvale St.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02605

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Risen

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

3:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1617 Lancaster Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

3:30 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

203

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1617 Lancaster Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-8-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

3-13-72

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

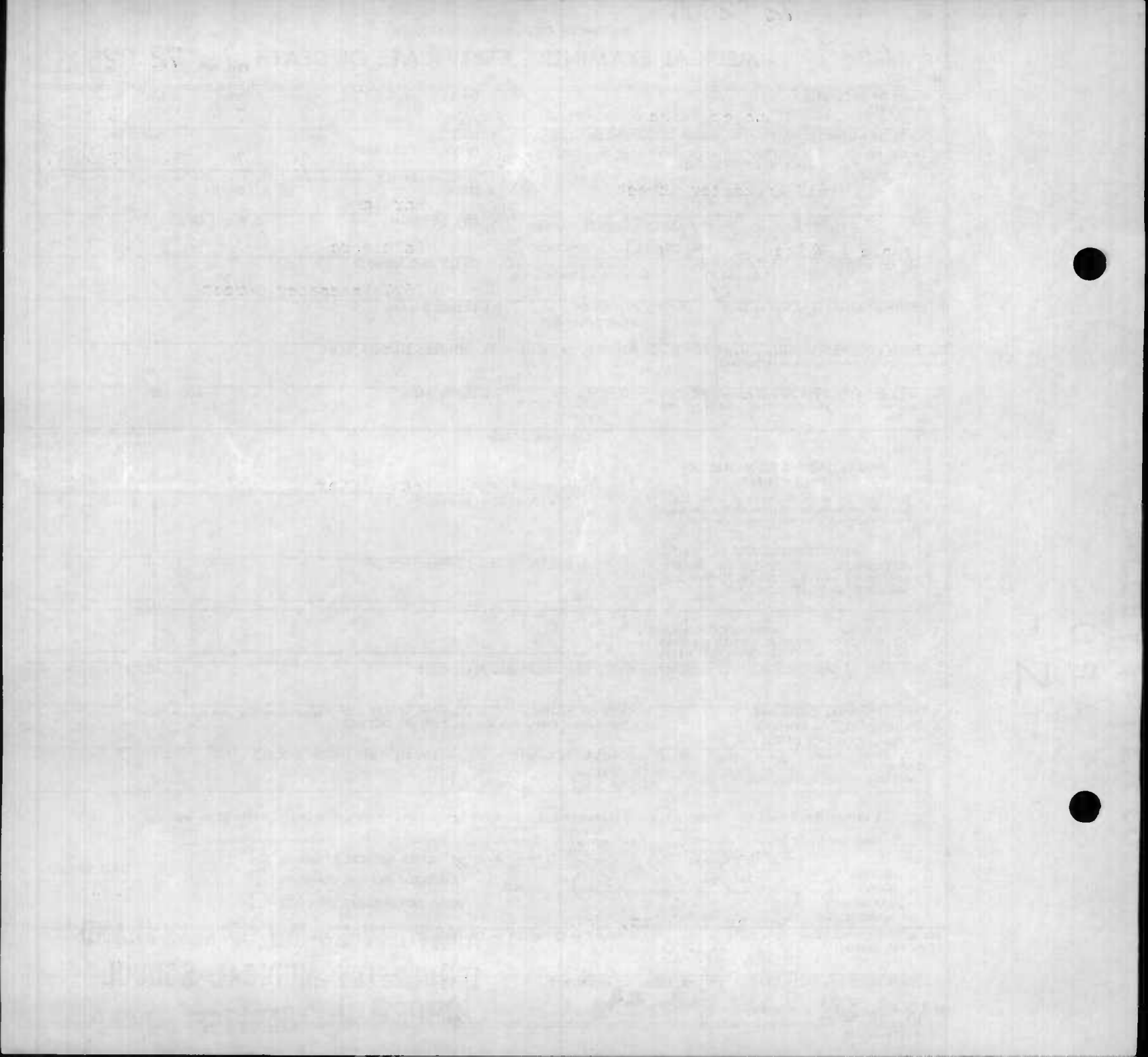
25B. NAME OF REGISTRAR

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
FUNERAL DIRECTOR (Name)

MAR 15 1972

Robert E. Spitz, M.D.

2 MORTUARY SERVICE - BCHD



K-612

72 02606

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

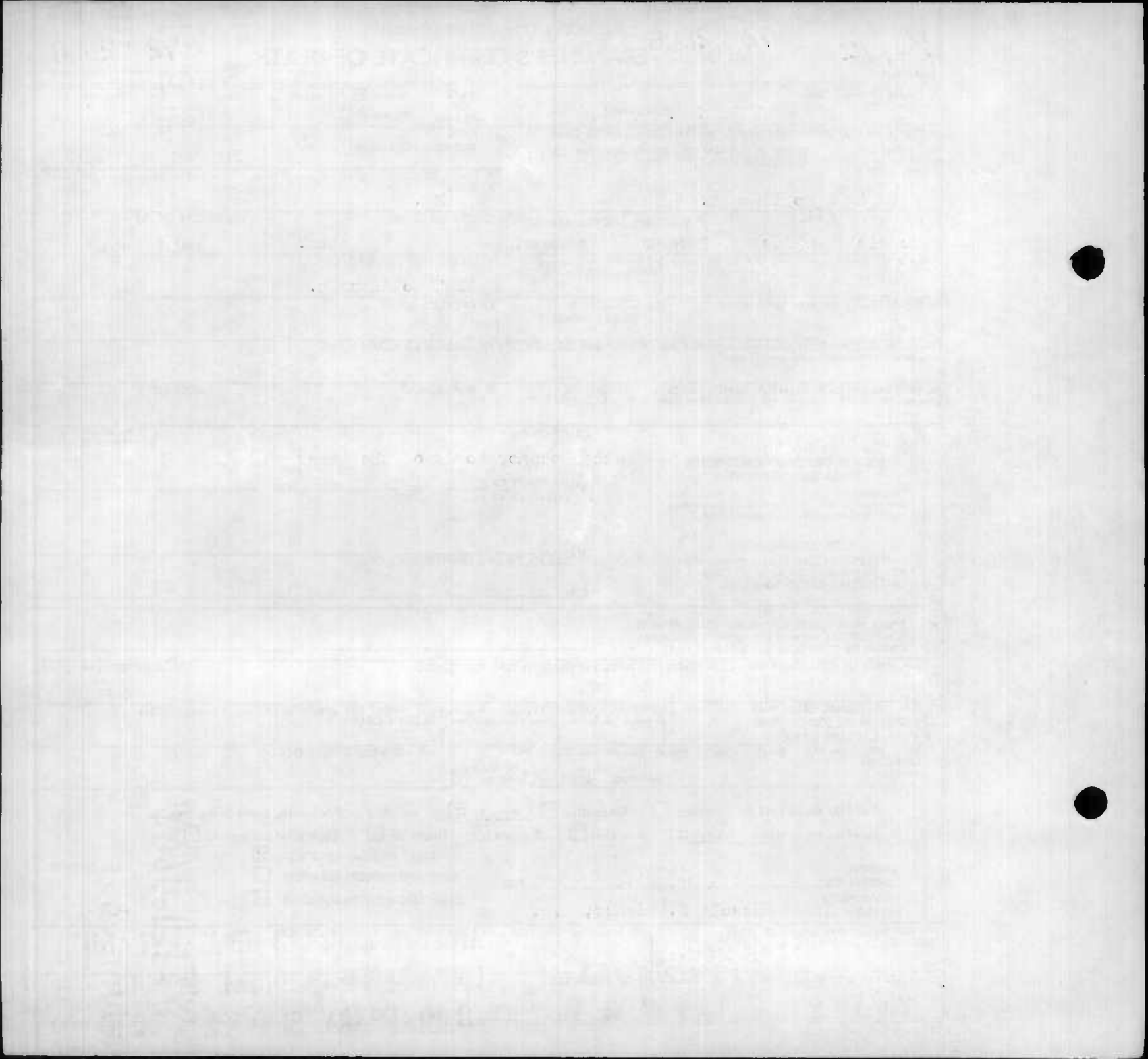
72 02606

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LUCILLE V. KREBS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1302 Hollins St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 1= 31 1972 11:35 a.m.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1902	
9. DATE OF BIRTH		10. AGE (in years lost birthday) 55	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		13. FATHER'S NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 571.81 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R S Fisher M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-31-72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-13-72	
24C. NAME OF CEMETERY OR CREMATOR		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR 1972000	
25C. FUNERAL DIRECTOR		ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



W-252

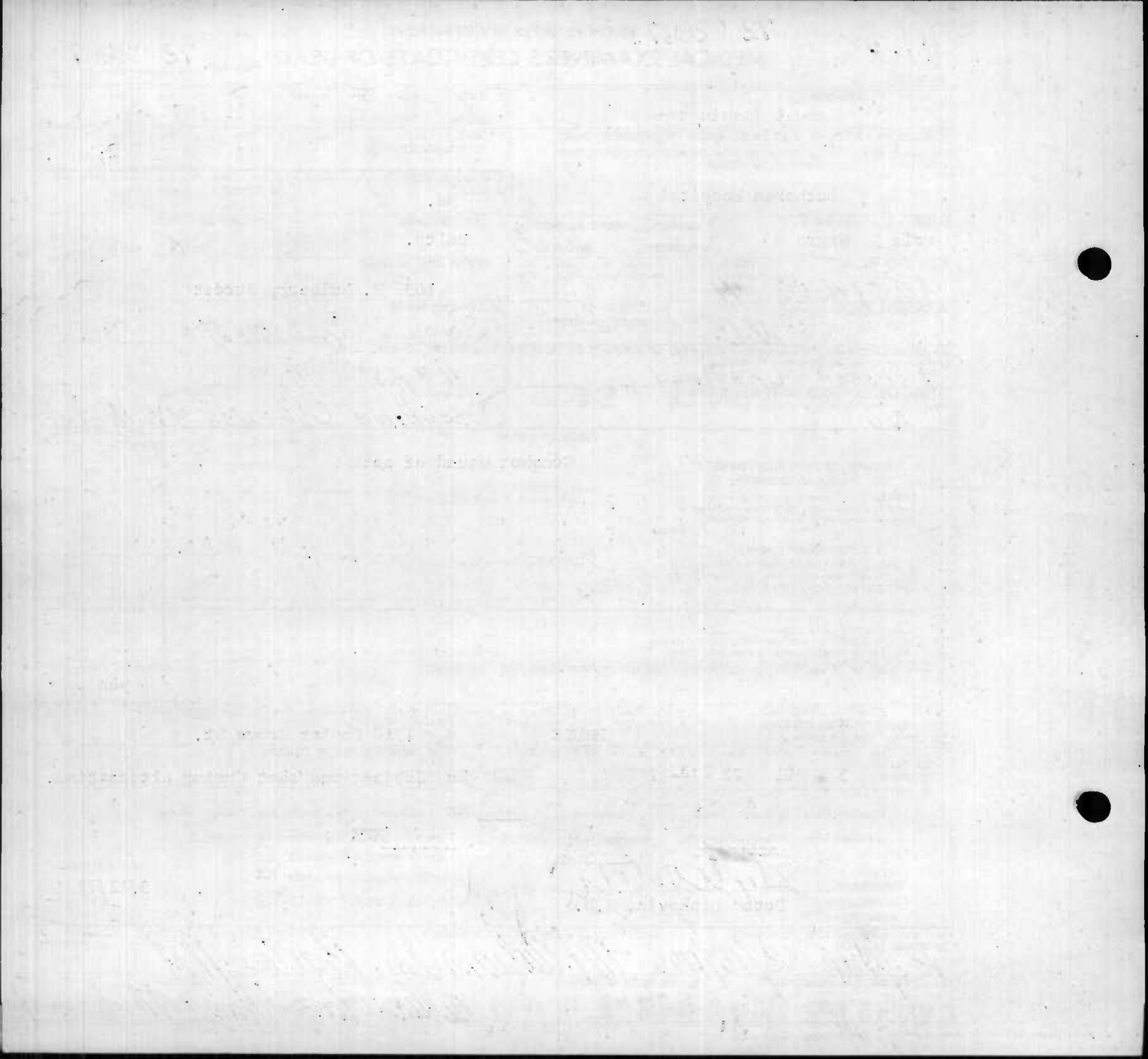
72 02607 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02607

BIRTH NO.

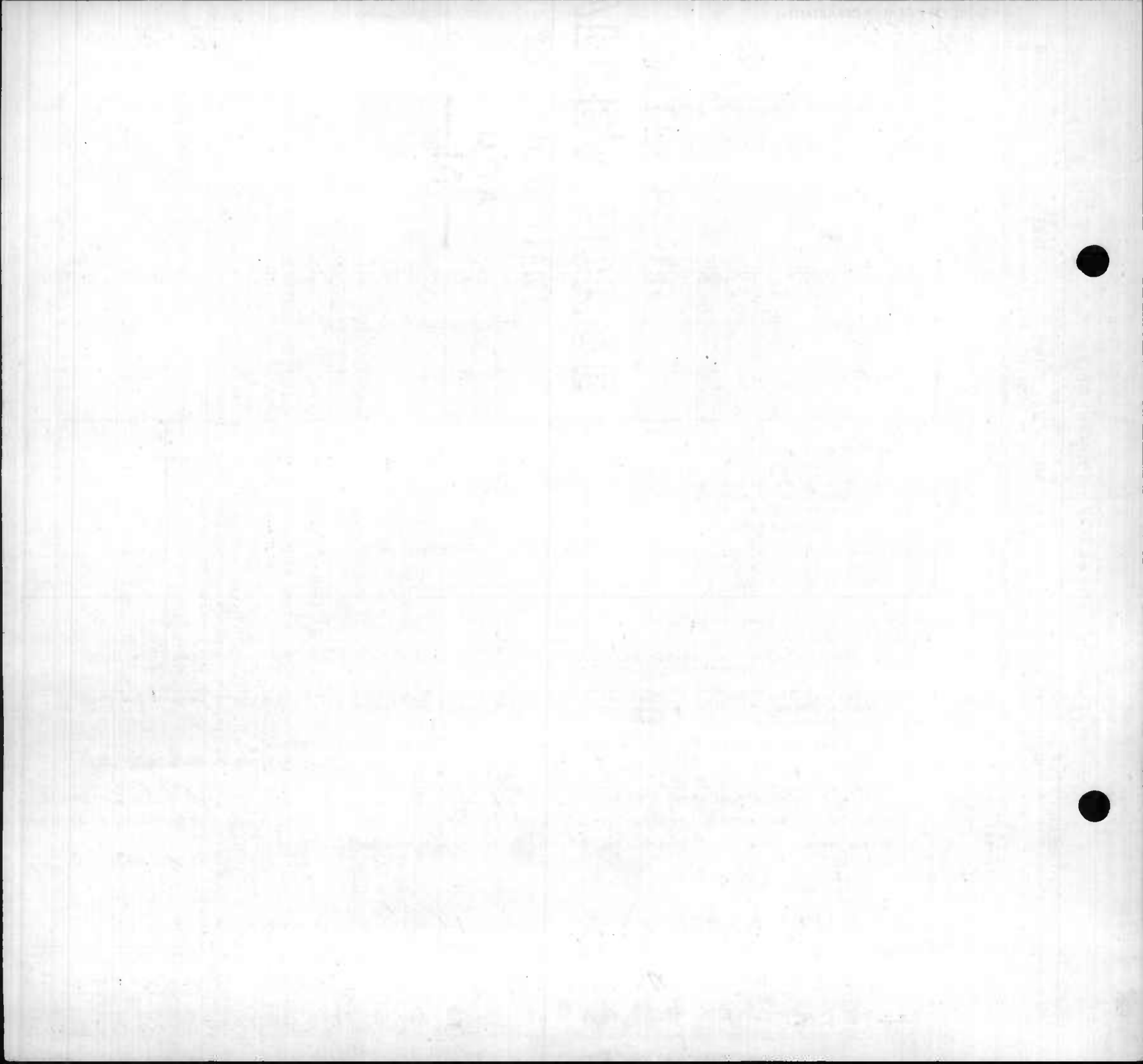
1. NAME OF DECEASED (Type or Print) Samuel Washington		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72 Hour 2:45 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2001	
9. DATE OF BIRTH April 14 1900		10. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel T. Washington		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Unemployed	
15. MOTHER'S MAIDEN NAME Mary ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Josephine Queen 1839 W. Mulberry St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, allice bldg., etc.) HOUSE	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1910 Poplar Grove St. 1506			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3 11 72 2:35 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject was shot during altercation.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/1972	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS William's Funeral Home 9199 Schrock St.	



FUNERAL DIRECTOR: IMPORTANT

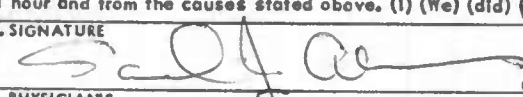
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

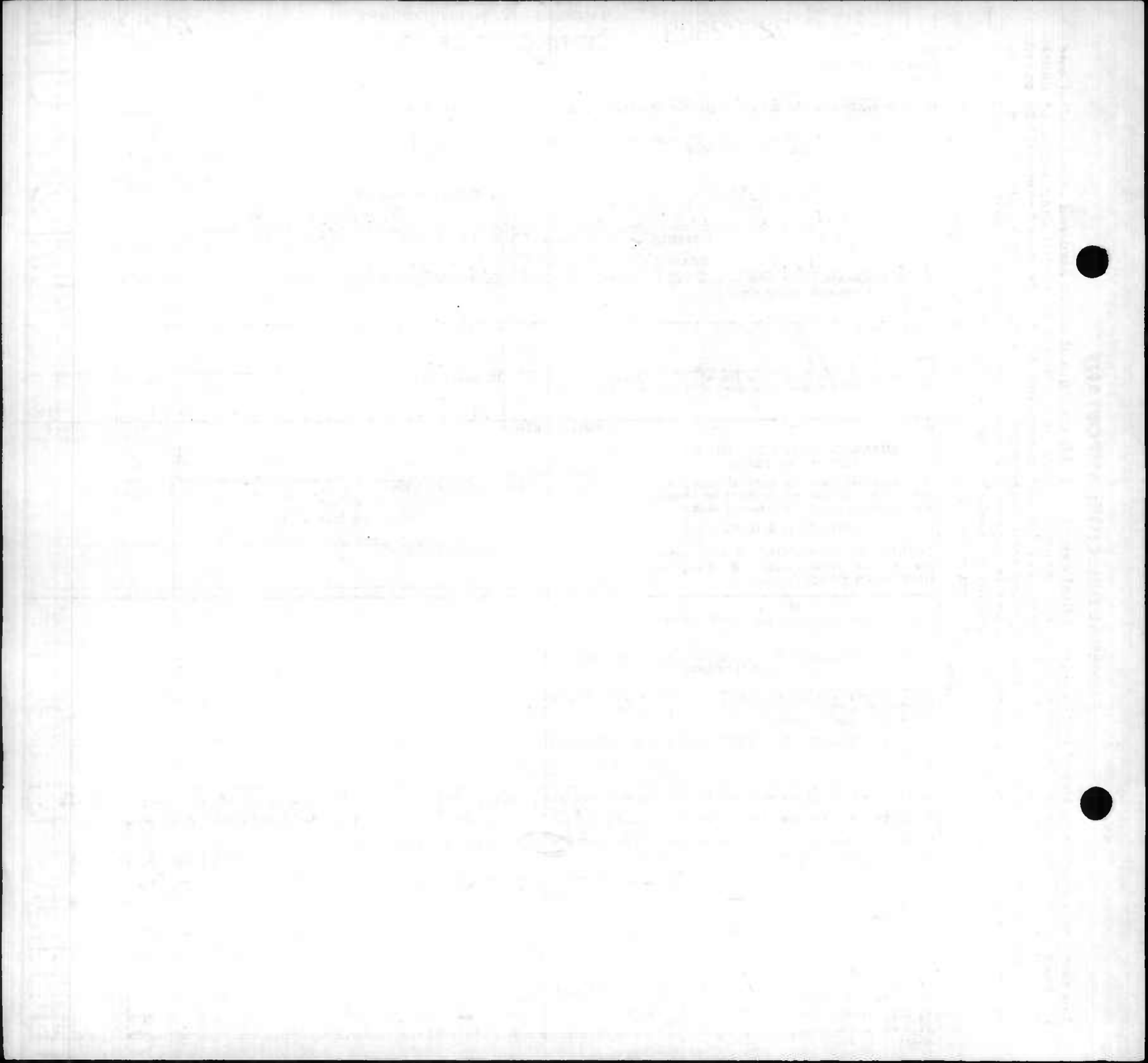
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02608	
T-600		72 02608		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BESSIE TERRY			2. DATE AND HOUR OF DEATH 3/8/72 9: P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 1918 N. MONROE ST. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND - BALTO. B. COUNTY 1504 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1918 N. MONROE ST		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1883	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CHASE CITY, VIRGINIA	
13. FATHER'S NAME ABRAM CARRINGTON			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT LILLIAN CLARK ADDRESS 1918 N. MONROE ST.	
18. 4/12/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ante-sclerotic Heart DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Ante-sclerotic Heart (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/10/68 19 to 3/8/72 19, that (I) (we) last saw the deceased alive on 3/8/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. G. ARNER			23B. DATE SIGNED 3/9/72		
23C. PHYSICIAN'S NAME (Type) W. G. ARNER			23D. ADDRESS 1855 Penna. ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/11/72		24C. NAME OF CEMETERY OR CREMATORY MT AUBURN	
24D. LOCATION (City, town, or county) (State) BALTO. MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972			
25B. NAME OF REGISTRAR EARL GILMUR		25C. FUNERAL DIRECTOR EARL GILMUR ADDRESS -1827 W. NORTH AVE.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02609	
R-152 72 02609		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Vashti Robinson		2. DATE AND HOUR OF DEATH 3-12-72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1505	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (D.O.A.)		C. CITY OR TOWN Balto.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F. 6. RACE N. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-31-13 9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) N. Carolina	
13. FATHER'S NAME Henry EVANS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Artis Peters		ADDRESS 5318 Walbash Ave.	
18. 15321		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death) Cancer of descend		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: colon with widespread metastasis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, to brain - etc		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/19/69 19 to 3/12/72 1972 that (I) (we) lost saw the deceased alive on 2/78/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 3/14/72	
23C. PHYSICIAN'S NAME (Type) Samuel J. Abrams		23D. ADDRESS 7220 Park Heights Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-72	
24C. NAME OF CEMETERY or CREMATORY MT. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR John E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Milton E. Elickson		ADDRESS 1129 N. Carolina St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

9653 1

72 02610

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02610

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nettie Grant

2. DATE AND HOUR OF DEATH

March 11, 1972

7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

505 N. Fulton Avenue
Baltimore, Maryland 21223

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

1603

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

505 N. Fulton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

2-23-84

9. AGE (in years last birthday)

78

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Warn Hundley

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Anna Montgomery 505 N. Fulton Avenue

18. 44071

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Acute Myocardial Failure

(B) DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerosis

(C) SEMI-DEGENERATION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/4 1972 to 3/11 1972 that (I) (we) lost saw the deceased alive on 3/11 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

GILBERT L. BAHFIELD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

3/13/72

23D. ADDRESS

Mrs. Anna Montgomery 505 N. Fulton Avenue Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-15-72

24C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 15 1972

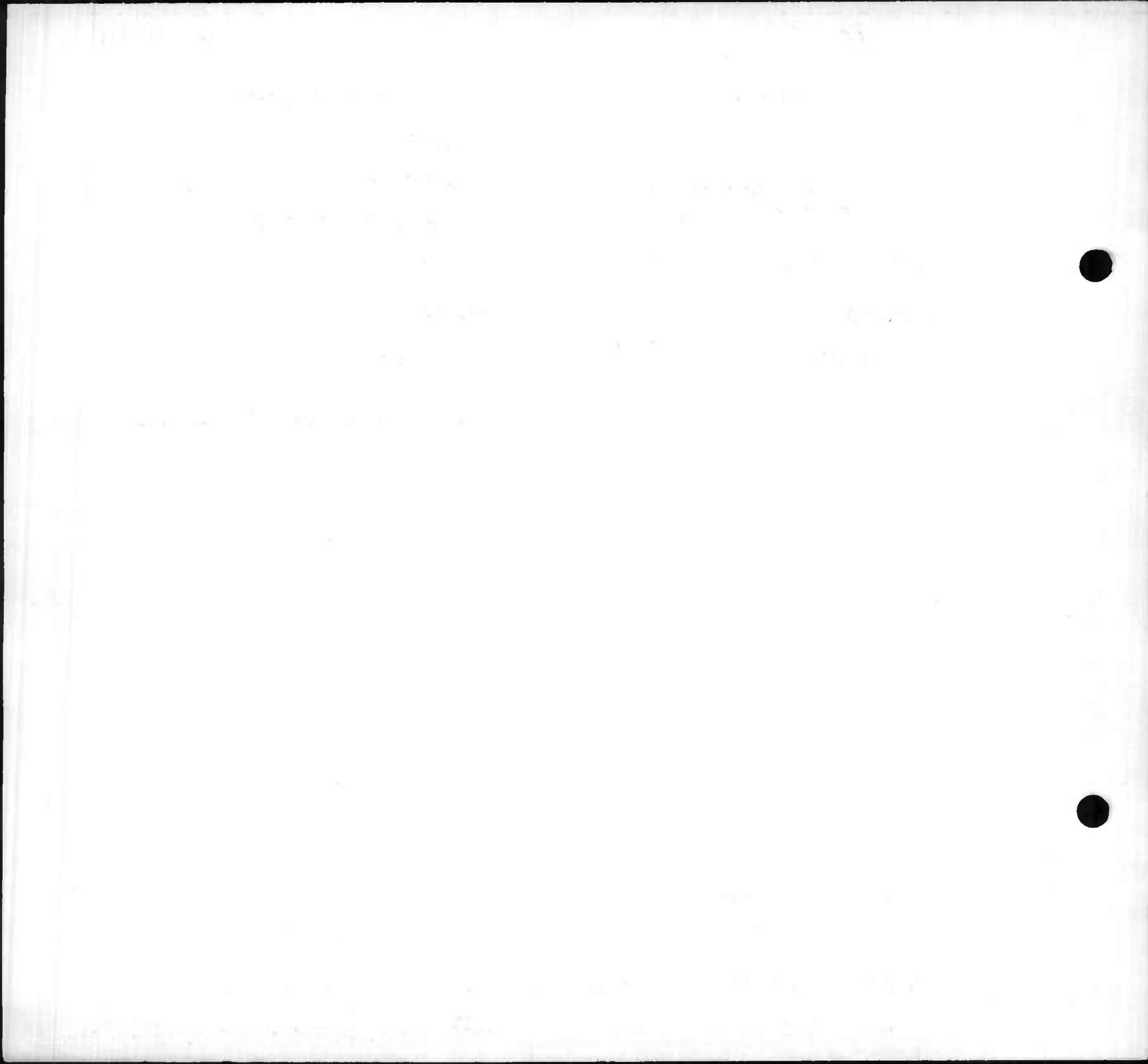
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

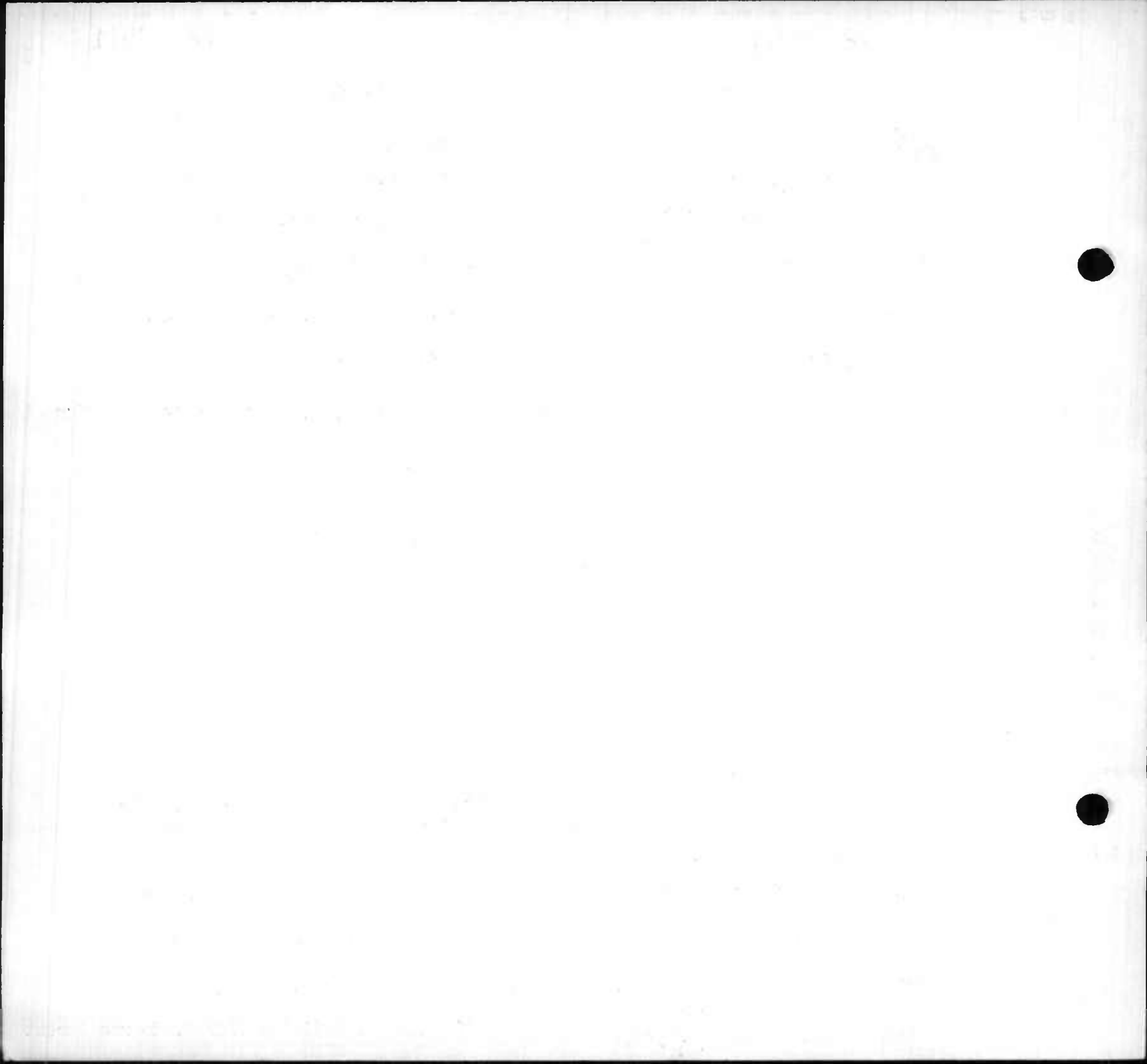
Arlington S. Phillips 1727 N. Monroe Street

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02611	
BIRTH NO. 72 02611							
1. NAME OF DECEASED (Type or Print) Lula Reynolds				2. DATE AND HOUR OF DEATH March 9, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1607			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1207 Poplar Grove Street			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-95		9. AGE (In years last birthday) 77	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Calvert Co., Maryland		
13. FATHER'S NAME John M. Brown			14. MOTHER'S MAIDEN NAME Elizabeth Gross				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 212-22-4184		17. INFORMANT ADDRESS Mr. Virgil Reynolds 1207 Poplar Grove Street		
18. 412.0 CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Cerebral Circulatory Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Hypertension, Atherosclerotic C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>more than 16 years.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3-9-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-95 19 to 3-9-72 19 that (I) (we) last saw the deceased alive on 3-26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Lucius W. Zeeper</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-11-72	
23C. PHYSICIAN'S NAME (Type) Lucius W. Zeeper M.D.				23D. ADDRESS 2231 Garrison Blvd. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 72 02612		CERTIFICATE OF DEATH		REG. NO. 72 02612	
1. NAME OF DECEASED (Type or Print) Lynden Archibald Webber				2. DATE AND HOUR OF DEATH Mar/ 10, 1972 2 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1502					
5. SEX M				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/02	
9. AGE (In years last birthday) 69				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steward		11. BIRTHPLACE (State or foreign country) BWI		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexandria Webber				14. MOTHER'S MAIDEN NAME Mary Bryant					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 086-14-6337		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ? Cardiomyopathy				(B) DUE TO, OR AS A CONSEQUENCE OF:				Unknown	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Massive ascites, 3600cc Possible rt. congestive heart failure				(C) DUE TO, OR AS A CONSEQUENCE OF:				3 mos. 3 mos.	
21A. DATE OF OPERATION 2		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) yes		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan. 21 19 72 to Mar. 10 19 72 , that (I) (we) last saw the deceased alive on Mar. 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert R. Wright, MD						23B. DATE SIGNED 3/10/72			
23C. PHYSICIAN'S NAME (Type) Robert Wright, SA Surg (R)						23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-14-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Faber, RD		25C. FUNERAL DIRECTOR Applington S. Phillips		25D. ADDRESS 1727 N. Monroe Street			

5/11/68

ST. LOUIS, MO.

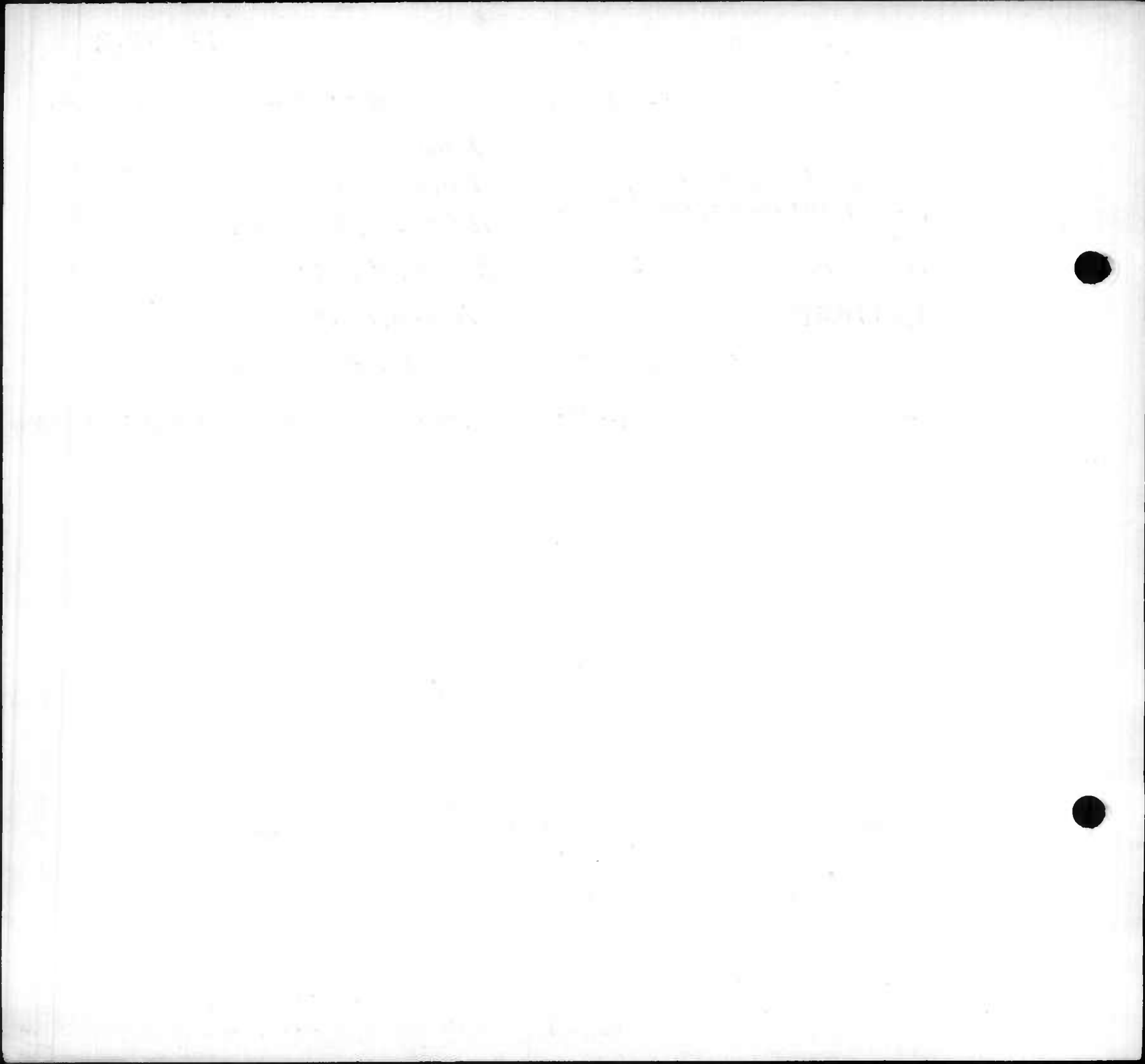
MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

[The body of the memorandum contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal report or memorandum.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02613		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02613	
1. NAME OF DECEASED (Type or Print) CLEMONS, CARL E			2. DATE AND HOUR OF DEATH 3-9-72 1 8⁴⁵ A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital Baltimore, Md. 21216			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1503		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1637 Ruxton Ave		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-1907 65	9. AGE (in years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-2539		17. INFORMANT Mrs. Bernadetta Anderson	
				ADDRESS 3228 Yosemite Avenue	
18. 149X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Coronary arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Ca - Throat DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-21-1972 to 3-9-1972 that (I) (we) last saw the deceased alive on 3-8-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 3/9/72		
23C. PHYSICIAN'S NAME (Type) [Signature]			23D. ADDRESS Arlington S. Phillips 1727 N. Monroe Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]			



T 460

BALTIMORE CITY HEALTH DEPARTMENT

72 02614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02614

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Tyrone Taylor		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 11 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 882 Bethune Road		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 11 72 3:00 a. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2562		6. SEX male 7. RACE Negro 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Dec. 31, 1949		10. AGE (In years last birthday) 22	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Taylor		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Ethel Ransom		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-50-2288		18. INFORMANT ADDRESS Mrs. Mary Taylor 882 Bethune Road	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) X			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 882 Bethune Rd		22D. TIME OF INJURY (APPROX.) Month Day Year Hour 3 11 72 3 a.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Deceased was playing "Russian roulette"	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 3/11/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	

OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

WASHINGTON, D. C.

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02615		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02615	
1. NAME OF DECEASED (Type or Print) <u>Edgar L. Steg</u>		2. DATE AND HOUR OF DEATH <u>3/13/72</u> <u>8:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bolton Hill Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>904</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3021 Trisby St.</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-13-01</u>	9. AGE (in years last birthday) <u>70 yrs</u>	10. If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO REPAIRMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CAB CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE STEG</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE HAGLE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-4026</u>		17. INFORMANT ADDRESS <u>MRS. ELLEN M. STEG (SAME)</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two Years</u> <u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>9 March</u> 19 <u>72</u> to <u>13 March</u> 19 <u>72</u> that <u>it</u> (we) last saw the deceased alive on <u>13 March</u> 19 <u>72</u> and that <u>in my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>it</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter H. Rheinstein, M.D.</u>		23B. DATE SIGNED <u>14 March 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>Peter H. Rheinstein, M.D.</u>		23D. ADDRESS <u>Bolton Hill Nursing Home, 1400 John Street, Baltimore, Maryland 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>3-16-72</u>	24C. NAME of CEMETERY or CREMATORY <u>Parkwood</u>	24D. LOCATION (City, town, or county) <u>Parkville,</u>	(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Sabin, M.D.</u>	25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	

1870

1871

1872

1873

1874

1875

1876

1877

1878

A534

72 02616

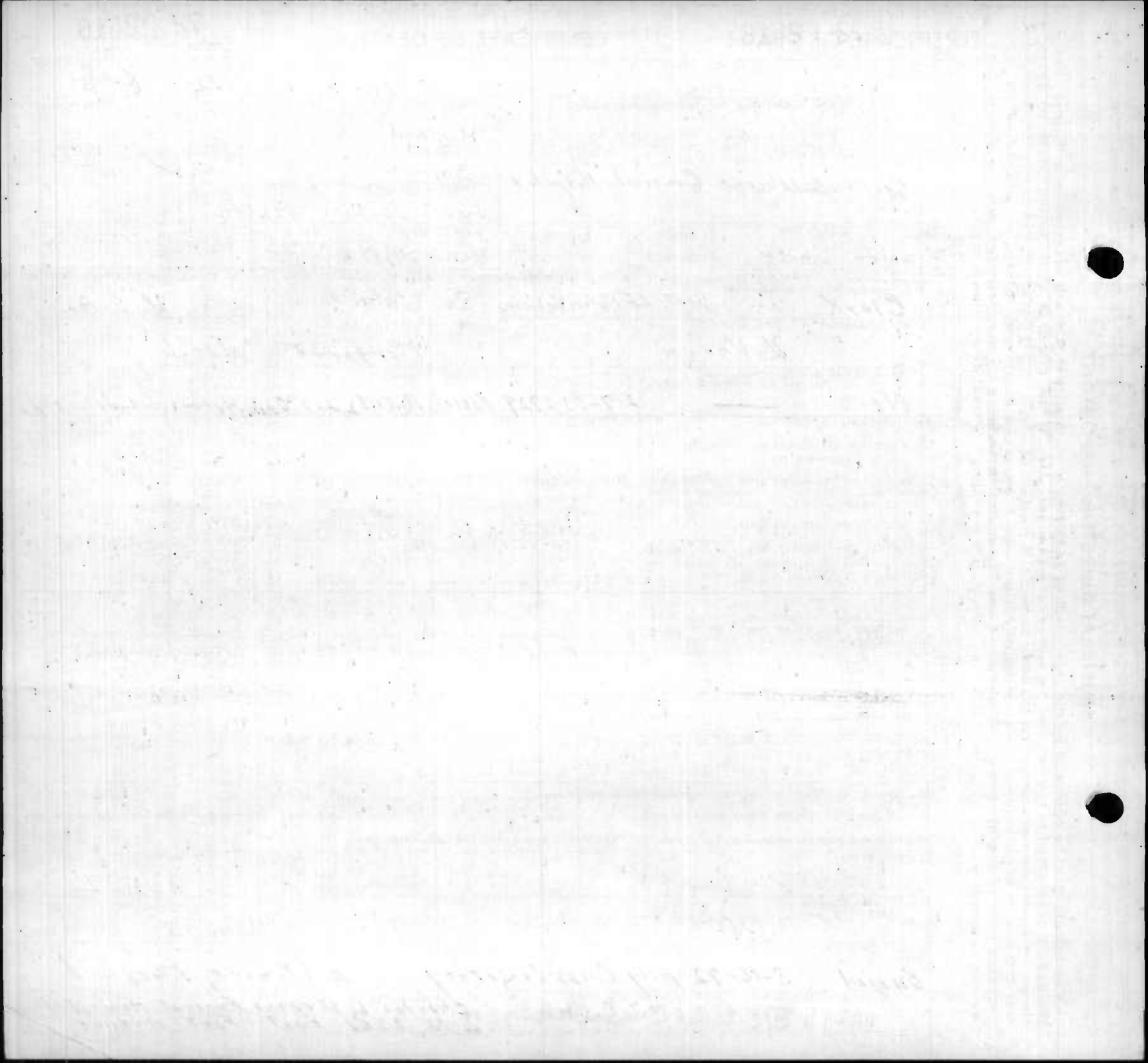
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02616

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Antlitz, Irene</i>		2. DATE AND HOUR OF DEATH <i>March 12, 1972</i> <i>6:35 P.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2404</i>		5. SEX <i>Female</i> 6. RACE <i>white</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1635 Jackson Street</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 28, 1916</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. of Motor Vehicles</i>		9. AGE (In years last birthday) <i>55</i>	
11. BIRTHPLACE (State or foreign country) <i>Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret Wood</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-03-2729</i>	
17. INFORMANT <i>Robert Antlitz</i>		ADDRESS <i>215 Oak Avenue Pasadena 196</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>CVA</i>	
19. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Colleen Juggas MD</i>		23B. DATE SIGNED <i>3/13/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>GRIGGS, E. A. MD.</i>		23D. ADDRESS <i>South Baltimore Gen. Hosp.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>3-16-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i>	
25D. ADDRESS <i>2615 East Fort Avenue</i>					

FUNERAL DIRECTOR: IMPORTANT

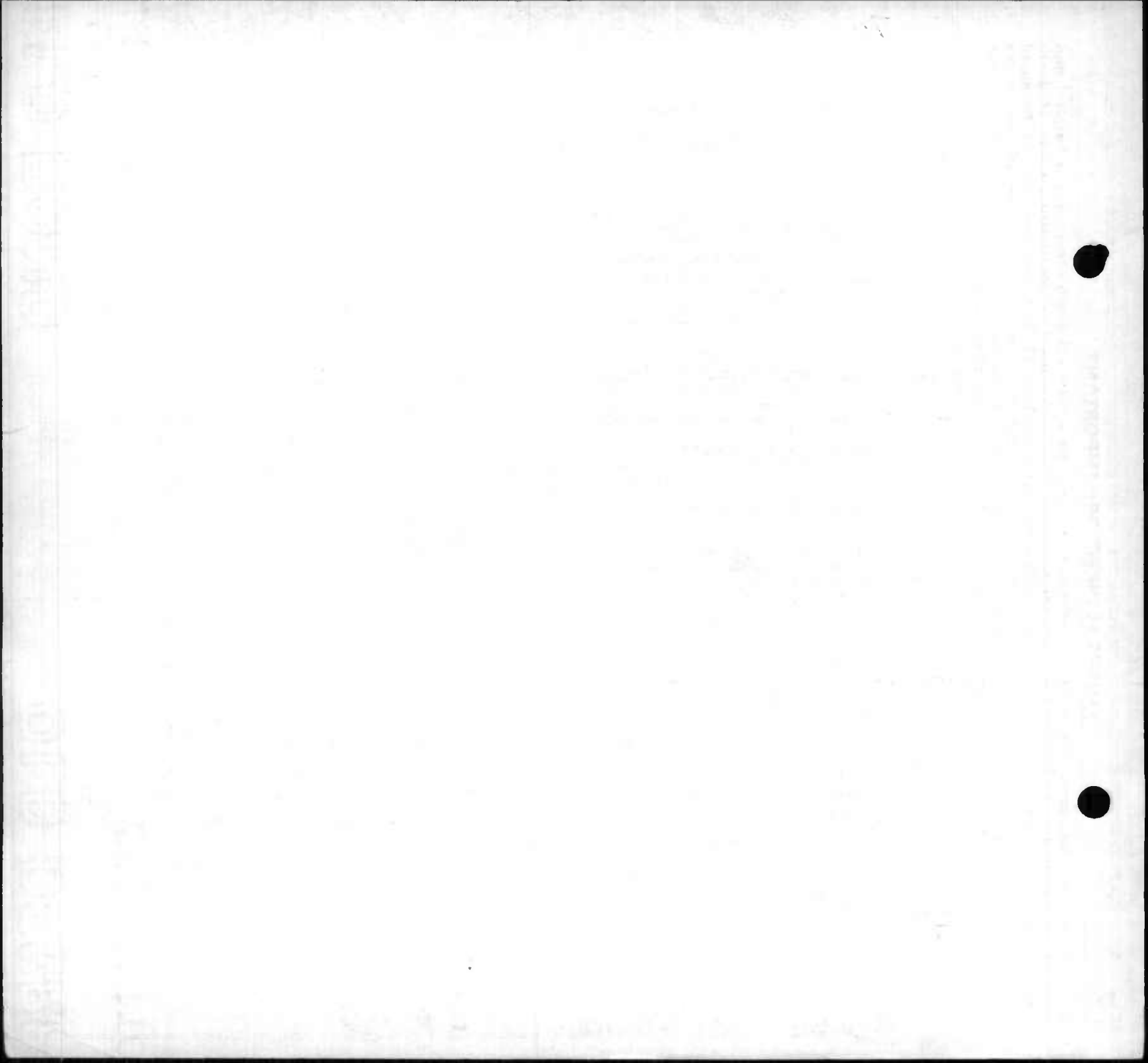
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72-2617		CERTIFICATE OF DEATH		72-2617	
1. NAME OF DECEASED (Type or Print) TERESA SHARP				2. DATE AND HOUR OF DEATH Feb 20, 1972 1230 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. CITY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSP 33rd + N CALVERT ST. BALT. MD 21218				C. CITY OR TOWN BALT.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE CAUCASIAN 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4/10/91		9. AGE (In years last birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HARRY MALONE				14. MOTHER'S MAIDEN NAME Mary Elsie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216 050900		17. INFORMANT VINCENT SHARP	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.4 14 E887X				CAUSE OF DEATH Acute renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Dehydration			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Depression (Acute)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ex @ hip							
19A. DATE OF OPERATION 3 2/9/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex @ hip		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 719 Belle Terre Ave			
21D. TIME OF INJURY (Approx.) Feb 5 72?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pt. Fell down			
22. I certify that (I) (the hospital) attended the deceased from 2/5/72 19 72 to 2/20 19 72 that (I) (we) lost saw the deceased alive on 2/20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert P. Doyle MD				23B. DATE SIGNED 2/20/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/25/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Brite. Md.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Charles J. Stevens		ADDRESS 1518 East Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02618</u>	
W-426 (Wilkinson) <u>72 02618</u>				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <u>Helen A. Wilkinson</u>				2. DATE AND HOUR OF DEATH <u>3/12/72 12:40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>CITY</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hosp</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/8/60</u> 9. AGE (In years last birthday) <u>12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Arthur Beuchelt</u>		14. MOTHER'S MAIDEN NAME <u>Helen Dunn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218 01 2801</u>		17. INFORMANT <u>Chart</u> ADDRESS	
18. <u>412.441 250.9</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>CVA (C)</u> DUE TO, OR AS A CONSEQUENCE OF:	
				(C) <u>ASCVD</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3/12</u> 19 <u>72</u> to <u>3/12</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>never</u> 19 <u> </u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George C. Samaras MD</u>				23B. DATE SIGNED <u>3/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>George C. Samaras MD</u>		23D. ADDRESS <u>Molt</u>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-15-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>B2 Hb Northern Cem</u>	
24D. LOCATION (City, town, or county) <u>B2 Hb Md</u>		24E. STATE (State) <u>Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1972</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Burger Funeral Home</u>		25D. ADDRESS <u>B2 Hb Md</u>	

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are faintly visible.

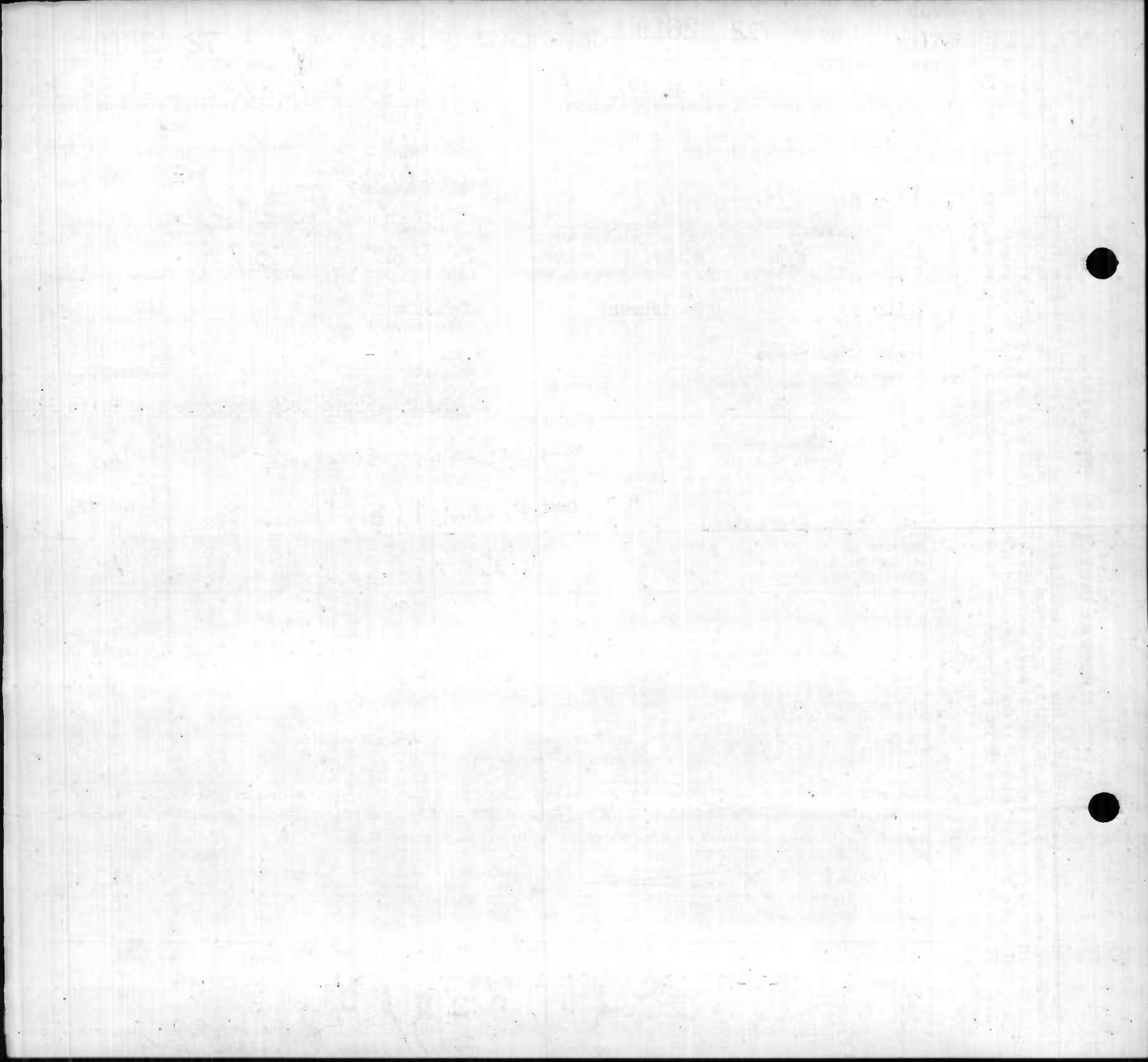
Handwritten text, mostly illegible due to fading and bleed-through. Some words like "and" and "the" are faintly visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "the" and "of" are faintly visible.

FUNERAL DIRECTOR: IMPORTANT

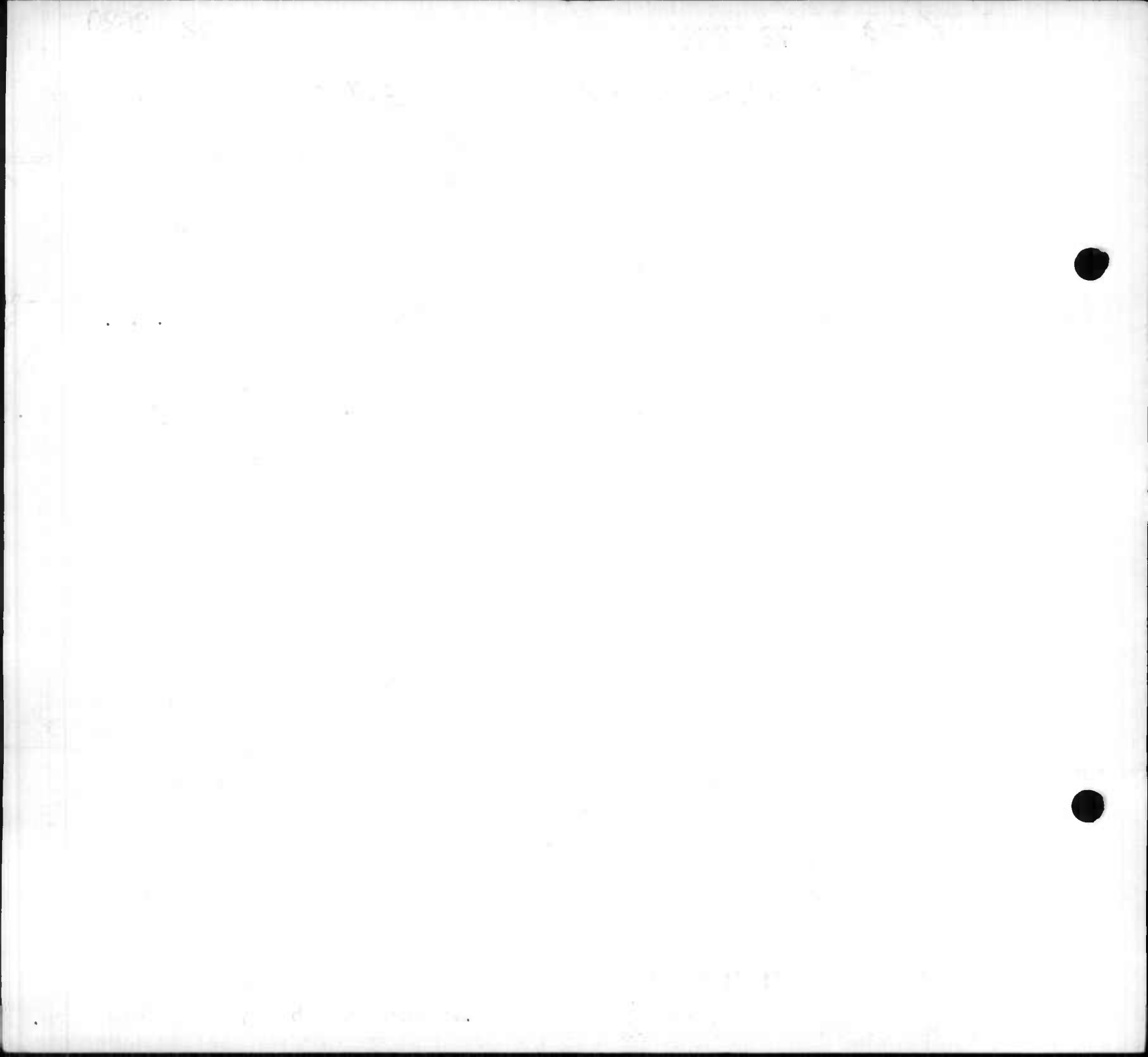
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. A-130				72 02619		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02619	
1. NAME OF DECEASED (Type or Print) Freida M. Abbott				2. DATE AND HOUR OF DEATH 3-10-72 3:55 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 7 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 1338		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-17-33		9. AGE (In years last birthday) 39	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonas Shawanessse				14. MOTHER'S MAIDEN NAME Edna -					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Eugene F. Abbott 2069 Rockrose Ave Balto 21211			
18. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MALLORY-WEISS SYNDROME DUE TO, OR AS A CONSEQUENCE OF: Portal hypertension Portal cirrhosis				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days months yr			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (the) (this hospital) attended the deceased from 3-1-1972 to 3-10-1972 , that (he) (we) lost saw the deceased alive on 3-10-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert S. Fagan				23B. DATE SIGNED 3-11-72				23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS DEGREE									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-14-72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Fagan, M.D.		25C. FUNERAL DIRECTOR Burgee Funeral Home, Balto Md.				ADDRESS By: Norma Burge Jr	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

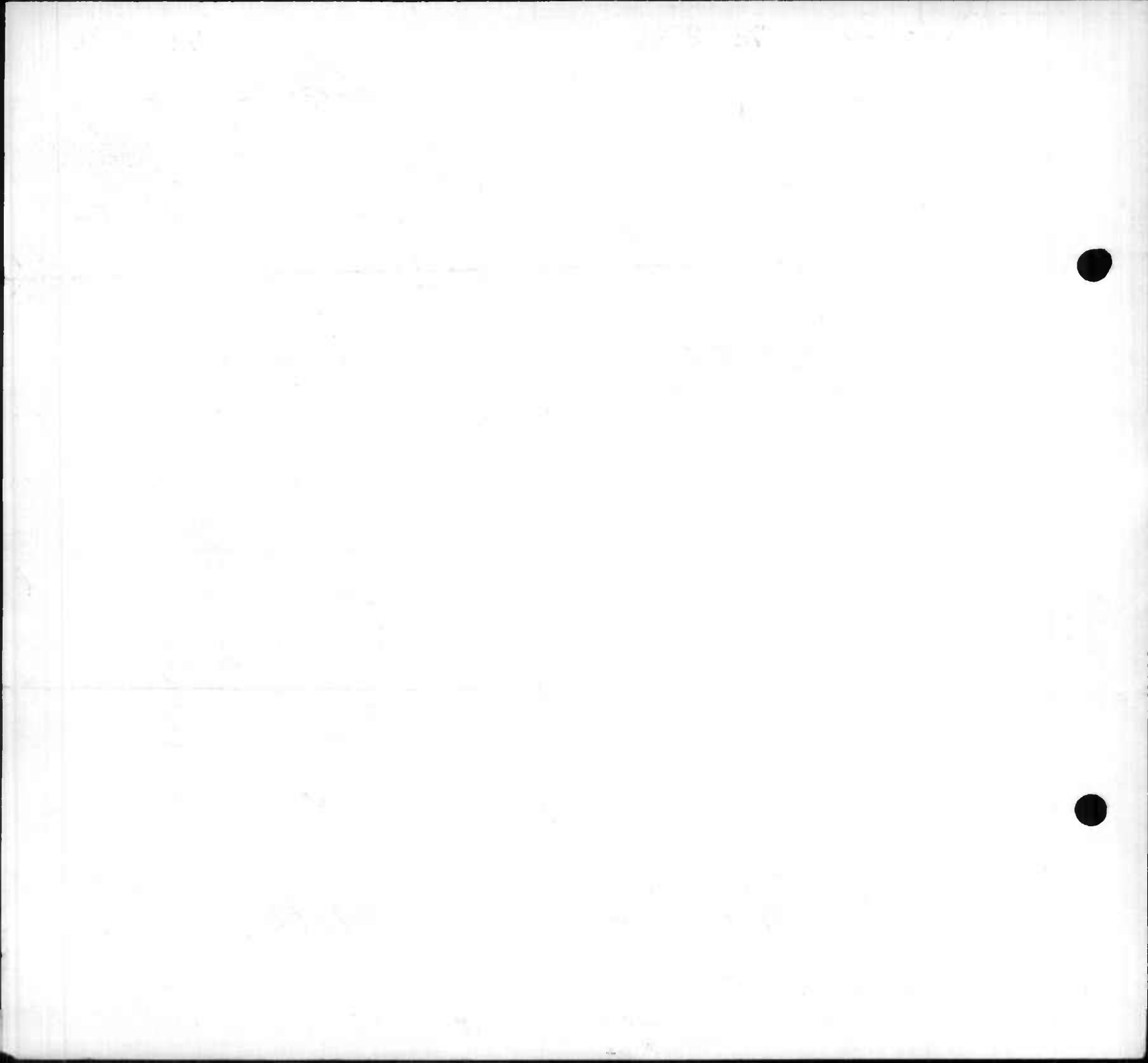
K-510		72 02620		BALTIMORE CITY HEALTH DEPARTMENT		72 02620	
BIRTH NO.		72 02620		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) PAUL W. KNOPP				2. DATE AND HOUR OF DEATH 3-9-72 11:55 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46 Baltimore				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2008			
5. SEX male				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 67	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?		11. BIRTHPLACE (State or foreign country) Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-03-0038		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. 410.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: ↑ (B) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Duodenal Ulcer.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/3/1972 to 3/9/1972 that (I) (we) last saw the deceased alive on 3/9/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. BASU				23B. DATE SIGNED 3/10/72		23C. PHYSICIAN'S NAME (Type) S. BASU	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/13/1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972				25B. NAME OF REGISTRAR B. E. Fisher		25C. FUNERAL DIRECTOR Truman Schwab	
26A. ADDRESS 4008 Massachusetts Ave.				26B. ADDRESS 3512 Frederick Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		72 02621		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02621	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CASEY, AARON E			
2. DATE AND HOUR OF DEATH 3-13-72 2:40 p.m.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION North CHARLES Gen Hosp				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md B. COUNTY 21223				C. CITY OR TOWN BALTIMORE			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 922 W. BALTIMORE ST			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-00	
9. AGE (In years last birthday) 71		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	
10B. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ELVIN CASEY				14. MOTHER'S MAIDEN NAME ANNA CASEY Bettie Sue?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 231091431		17. INFORMANT Anna L. Casey - 922 W. Baltimore St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Ca of The Lung				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH undetermined			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD				yes			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-18-72 19 72 to 3-13 19 72 that (I) (we) last saw the deceased alive on 3-13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Manankil				23B. DATE SIGNED 3-13-72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Ruperto MANANKIL				23D. ADDRESS NORTH CHARLES GEN. HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3/17/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Beth. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. C...			



1

72 02622 BALTIMORE CITY HEALTH DEPARTMENT

72 02622

E-212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Russell Edward Esposito		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 11 Year 72		Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 525 S. Luzerne Avenue		3. DATE PRONOUNCED DEAD Month 3 Day 11 Year 72		Hour 5:40 p. M.
6. SEX male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12/28/1922		10. AGE (In years last birthday) 49	11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM L. ESPOSITE		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
15. MOTHER'S MAIDEN NAME MARIE S. HIPLEY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES UNWH		17. SOCIAL SECURITY NO. 212-12-229
18. INFORMANT MR. WM. M. ESPOSITE		19. ADDRESS 817 TULNASTAZ		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. DUE TO, OR AS A CONSEQUENCE OF:		26. DUE TO, OR AS A CONSEQUENCE OF:
27. MEDICAL CERTIFICATION I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)		28. DATE 3/15/72		29. NAME OF CEMETERY or CREMATORY OAKLAWN CEMETERY
30. DATE OF OPERATION 2		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? (Yes or No) yes
33. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
36. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		37. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		38. HOW DID INJURY OCCUR?
39. DATE REC'D BY HEALTH DEPT. MAR 15 1972		40. NAME OF REGISTRAR J. J. J. J.		41. FUNERAL DIRECTOR J. J. J. J.
42. DATE 3/15/72		43. NAME OF CEMETERY or CREMATORY OAKLAWN CEMETERY		44. LOCATION (City, town, or county) (State) BALTIMORE MD.
45. DATE REC'D BY HEALTH DEPT. MAR 15 1972		46. NAME OF REGISTRAR J. J. J. J.		47. FUNERAL DIRECTOR J. J. J. J.
48. ADDRESS 2525 FLEET ST.		49. ADDRESS 2525 FLEET ST.		50. ADDRESS 2525 FLEET ST.

15/02/2025

2002

42-24 Williamsburg 290217C

Kenneth Tyler Morris Shipley

2015-2016 MC. Vol. 10, No. 1

Serial 2/12/72 Oakland Cemetery Baltimore 1972

S-361

72 02623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02623

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Strubel				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 9 72 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 716 S. Luzerne Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 9 72 4:00 p.			
6. SEX male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH JAN. 20, 1921				10. AGE (In years last birthday) 51		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME STEPHEN STRUBEL			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLISHER				14B. KIND OF BUSINESS OR INDUSTRY KIRK SILVER			
15. MOTHER'S MAIDEN NAME SIERAK				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES ARMY WWII			
17. SOCIAL SECURITY NO. 220-01-6127				18. INFORMANT ADDRESS MRS. CLARA STRUBEL 716 S. LUZERNE AVE			
19. CAUSE OF DEATH 571.81 Fatty metamorphosis of liver DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/14/72		24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR RAYMOND D. KACZOROWSKI		ADDRESS 2525 FLEET ST.	

Yes Army and so on with Glass Journal for St. Louis
Polisher Kirk Silver U.S.A. Stephen Journal
March 20 1931

April 21/32 L. Journal Camp D. H. H. H.
April 21/32 L. Journal Camp D. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02624		REG. NO. 72 02624	
BIRTH NO. 72 02624		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CARL E. JOHNSON		2. DATE AND HOUR OF DEATH MARCH 9, 1972 7:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 35		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY 103			
		5. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2524 FOSTER AVENUE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-23-00	9. AGE (in years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
13. FATHER'S NAME ELHERIGE JOHNSON		12. CITIZEN OF WHAT COUNTRY U. S. A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 245-43-7857		17. INFORMANT MRS. LORA JOHNSON	
				ADDRESS 2524 FOSTER AVE	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: (B) ACUTE DIAPHRAGMATIC MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS 4 DAYS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/3/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TEMPORARY PACE MAKER INSERTION FOR BRADYCARDIA		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 3. 8. 1972 19 72 to 3. 9 19 72 that (B) (we) last saw the deceased alive on 3. 9 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rustum. Irani		M.D. DEGREE M.D.		23B. DATE SIGNED March 9, 1972	
23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI		23D. ADDRESS CHURCH HOME AND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MARCH 13 1972		24C. NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL PARK CEM.	
24D. LOCATION 2525 FLEET ST.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR Raymond A. Kaczorowski		25C. FUNERAL DIRECTOR Raymond A. Kaczorowski	
				ADDRESS 2525 FLEET ST.	

Ben. J. Lee

Mrs. Lee, 224 1/2 1st St. N.W.

For sale to the public at the

of the

G-526

72 02625

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02625

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PETER GANZERMILLER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 8 Year 1972 Hour 7:50 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 5-10-72		3. DATE PRONOUNCED DEAD Month March Day 8 Year 1972 Hour 7:50 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH FEB 4, 1946		10. AGE (In years last birthday) 26	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE GANZERMILLER		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2644	
15. MOTHER'S MAIDEN NAME MARY ENDRES		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218-48-3086		18. INFORMANT MRS. CARROL GANZERMILLER ADDRESS 5513 SARRILL RD	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 780.2 Death occurring after apparent seizure (by history)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2		21. AUTOPSY? (Yes or No) Yes	
22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
24. TIME (Month) (Day) (Year) (Hour) (Approx.)		25. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		27. HOW DID INJURY OCCUR?	
28. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 9, 1972	
29. BURIAL CREMATION, REMOVAL (Specify) BURIAL		30. DATE MAR. 13, 1972	
31. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEM.		32. LOCATION (City, town, or county) (State) BALTIMORE MD.	
33. DATE REC'D BY HEALTH DEPT. MAR 15 1972		34. NAME OF REGISTRAR RAYMOND L. KACZOROWSKI	
		35. FUNERAL DIRECTOR ADDRESS 2525 FLEET ST.	

5-1-1972 - Completion of cause of death on a pending medical examiner death certificate
Charles S. Springate, M.D.

HRS

5-10-1972 - Change of Mother's maiden name from Margaret Anderson to Margaret Mary Endres
by Birth Certificate of Peter John Ganzermiller (G-40961 - 1946), also date of
birth from Jan. 4, 1946 to Feb. 4, 1946. Affidavit of Mother, Margaret Mary Endres.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>11-452</u>				72 02626		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 02626</u>	
1. NAME OF DECEASED (Type or Print) <u>Ferdinand E. Williams</u>						2. DATE AND HOUR OF DEATH <u>3-13-72</u> <u>5 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2641</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4308 Anntana Ave.</u> <u>21206</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-24-1908</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Monumental Mach.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-03-4768</u>		17. INFORMANT <u>4308</u> ADDRESS <u>Mrs. Isabelle Williams</u> <u>Anntana Ave.</u>			
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 4</u> 19 <u>72</u> to <u>Feb. 13</u> 19 <u>72</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We did) (did not) view the body after death.									
23A. SIGNATURE <u>Jason H. Gaskel</u> DEGREE						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3-14-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jason H. Gaskel, M.D.</u> DEGREE						23D. ADDRESS <u>637 S. Conkling St. Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-15-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Mem. Park</u>		24D. LOCATION <u>Balto.</u>		Md.	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 15 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Pabst</u>		25C. FUNERAL DIRECTOR <u>Helma A. Hoffmann</u>		ADDRESS <u>3218 Hudson St</u>			

[illegible]

1992-1993 1994-1995

• **Defect**

John G. Thompson

References

1950

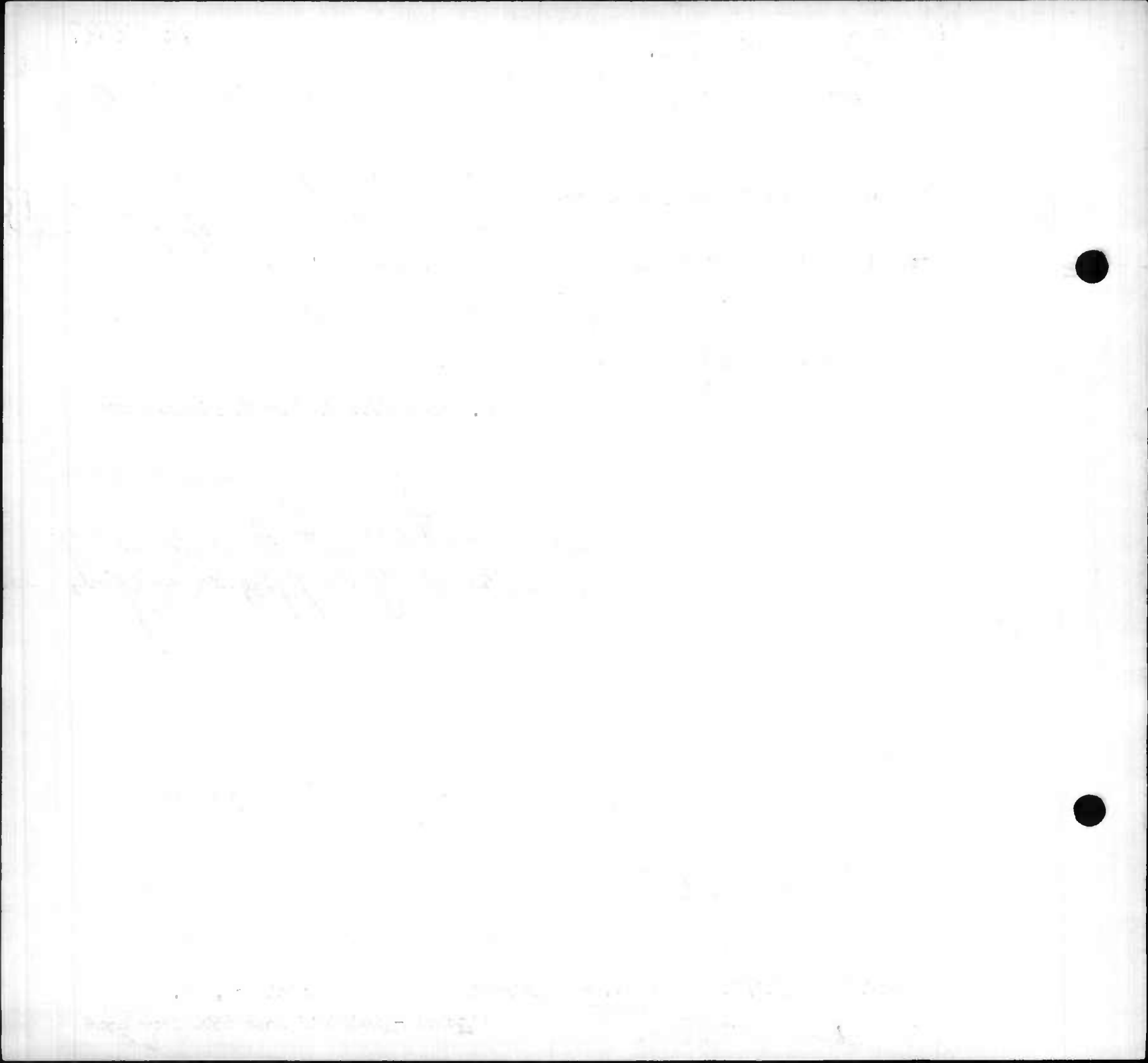
• CFI

Journal

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

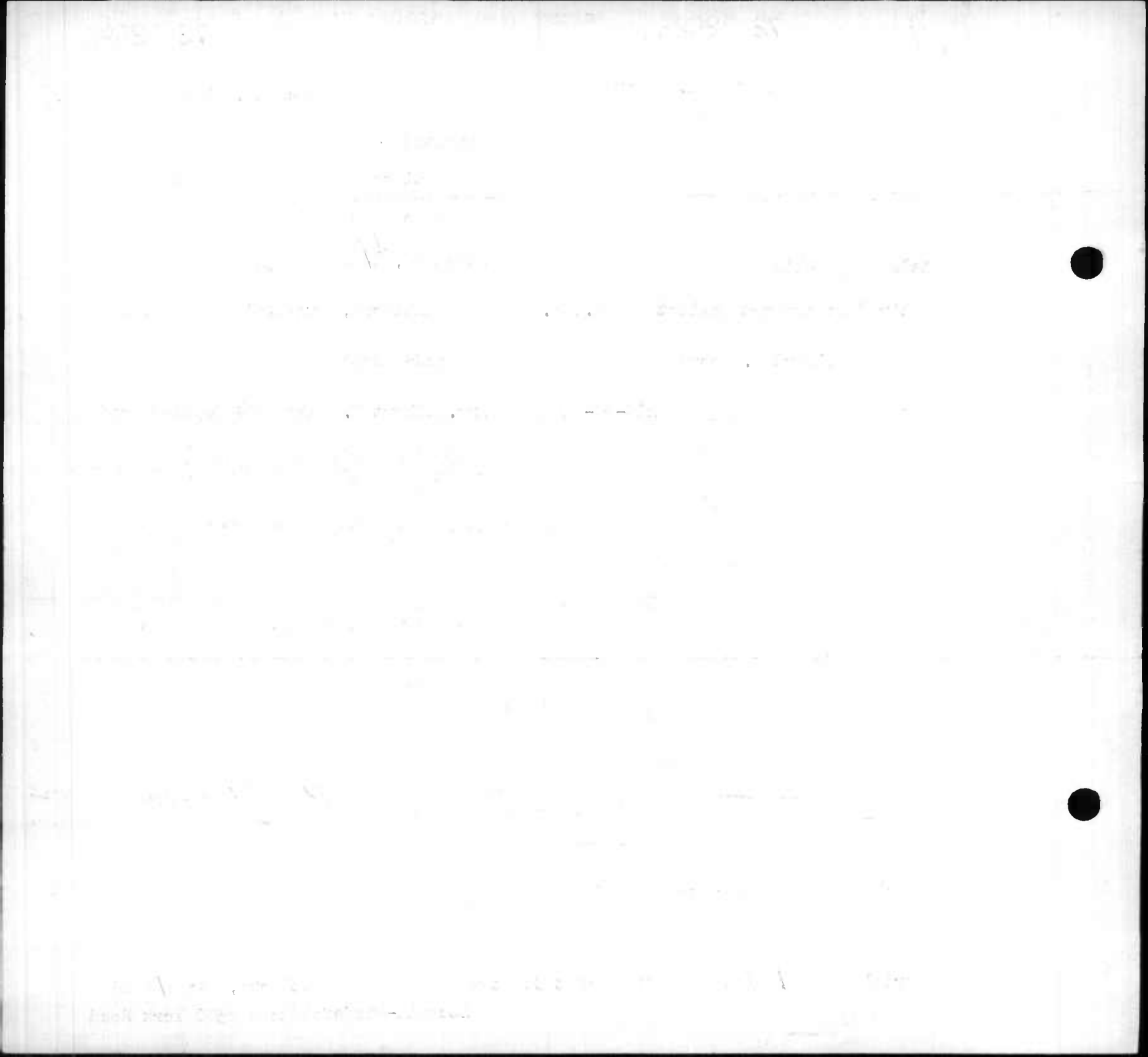
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02627	
1. NAME OF DECEASED (Type or Print) DORRIDA, ALBERT EDWIN		2. DATE AND HOUR OF DEATH 3-11-72 7:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GEN. HOSP.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO			
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 5-15-01		9. AGE (In years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT				10B. KIND OF BUSINESS OR INDUSTRY DOUBLE TOWER		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALBERT DORRIDA				14. MOTHER'S MAIDEN NAME EUSEBIA DAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marguerite Hipsley		ADDRESS 4103 Roland Ave	
18. 492 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Pulmonary Disease (B) DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMPHYSEMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-8-72 to 3-11-72 that (I) (we) last saw the deceased alive on 3-11-72 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Manankil				23B. DATE SIGNED 3-11-72		23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/14/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972			
25B. NAME OF REGISTRAR Robert E. Talley, M.D.				25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home			
25D. ADDRESS 6500 York Road							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600 72 02628		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02628	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Albert H. Moore		March 11, 1972 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Long Green Nursing Home		Maryland C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 304 Hopkins Road					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1910	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Management Analyst		10B. KIND OF BUSINESS OR INDUSTRY Vet. Adm.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Albert B. Moore		14. MOTHER'S MAIDEN NAME Maude Hutt		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO. 215-44-8180		17. INFORMANT Mrs. Albert H. Moore	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 403X1+250.9 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident with Cerebral Edema (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Nephrosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos. ? ?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 17 1971 to March 19 1972 that (I) (we) last saw the deceased alive on Mar 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. H. Kammer, Jr.		23B. DATE SIGNED 13 Mar 72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/72		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR John E. Gabel, M.D.	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25D. ADDRESS 6500 York Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02629	
G-362		72 02629	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Alice R. Goodrich		2. DATE AND HOUR OF DEATH 3/11/72 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5307 ST. ALBANS WAY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2712	
5. SEX F		6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10 30 1881		9. AGE (In years last birthday) 90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John F. Requardt		14. MOTHER'S MAIDEN NAME Bertha Jeager	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220443794	
17. INFORMANT V. Goodrich Ry tina		ADDRESS same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Atherosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 to March 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 3-13-72	
23C. PHYSICIAN'S NAME (Type) [Signature]		23D. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/72	
24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) Reistertown Rd Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR [Signature]		ADDRESS Hitchett-Wiedefeld Home 6500 York Rd	

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

179

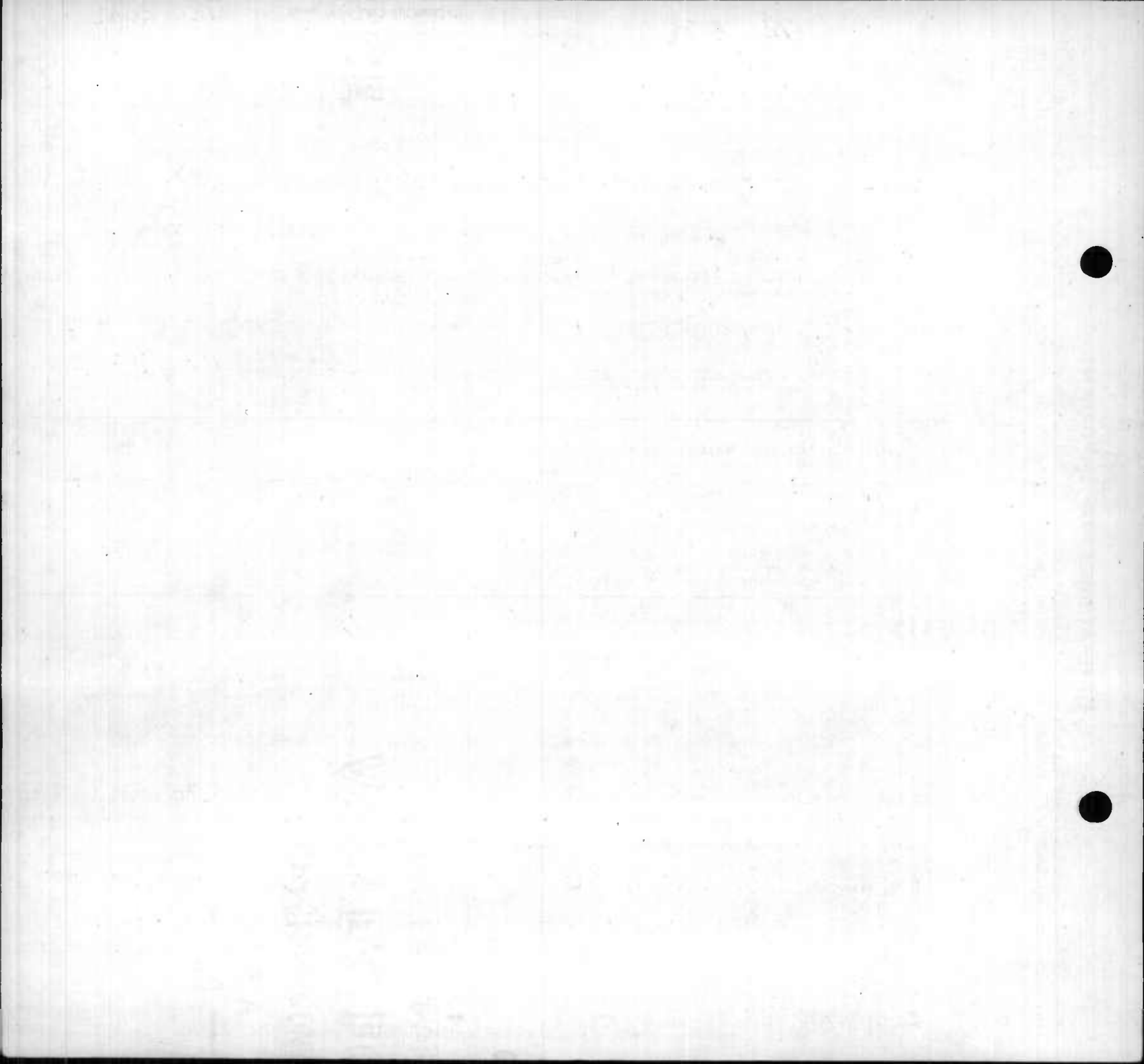
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 72 02630		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02630	
BIRTH NO.		1. NAME OF DECEASED (Type and print) <i>Helen Johnson</i>		2. DATE AND HOUR OF DEATH <i>3/10/1972 2:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1506</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>621 Poplar Grove St</i>					
5. SEX <i>F</i>	6. RACE <i>BLACK</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/7/196</i>	9. AGE (In years last birthday) <i>75</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Robert Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Lomax</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>108-26-4978</i>		17. INFORMANT <i>Brown</i> ADDRESS <i>Mrs. Ruth Brown, Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>412.412.50.9</i> Pneumonia		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Art Scler. Card Vas. Dis.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Decubitus ulcers</i>		<i>days.</i>	
(C) <i>Diabetes mellitus</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2-27-1972</i> to <i>3-10-1972</i> that (I) (we) last saw the deceased alive on <i>3-10-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D.S. Karbhari</i>		23B. DATE SIGNED <i>3/10/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>D.S. KARBHARI</i>		23D. ADDRESS <i>Lutheran Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/14/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>A/A County Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 15 1972</i>		25B. NAME OF REGISTRAR <i>Walter E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Walter E. Taylor, Jr.</i>	
25D. ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

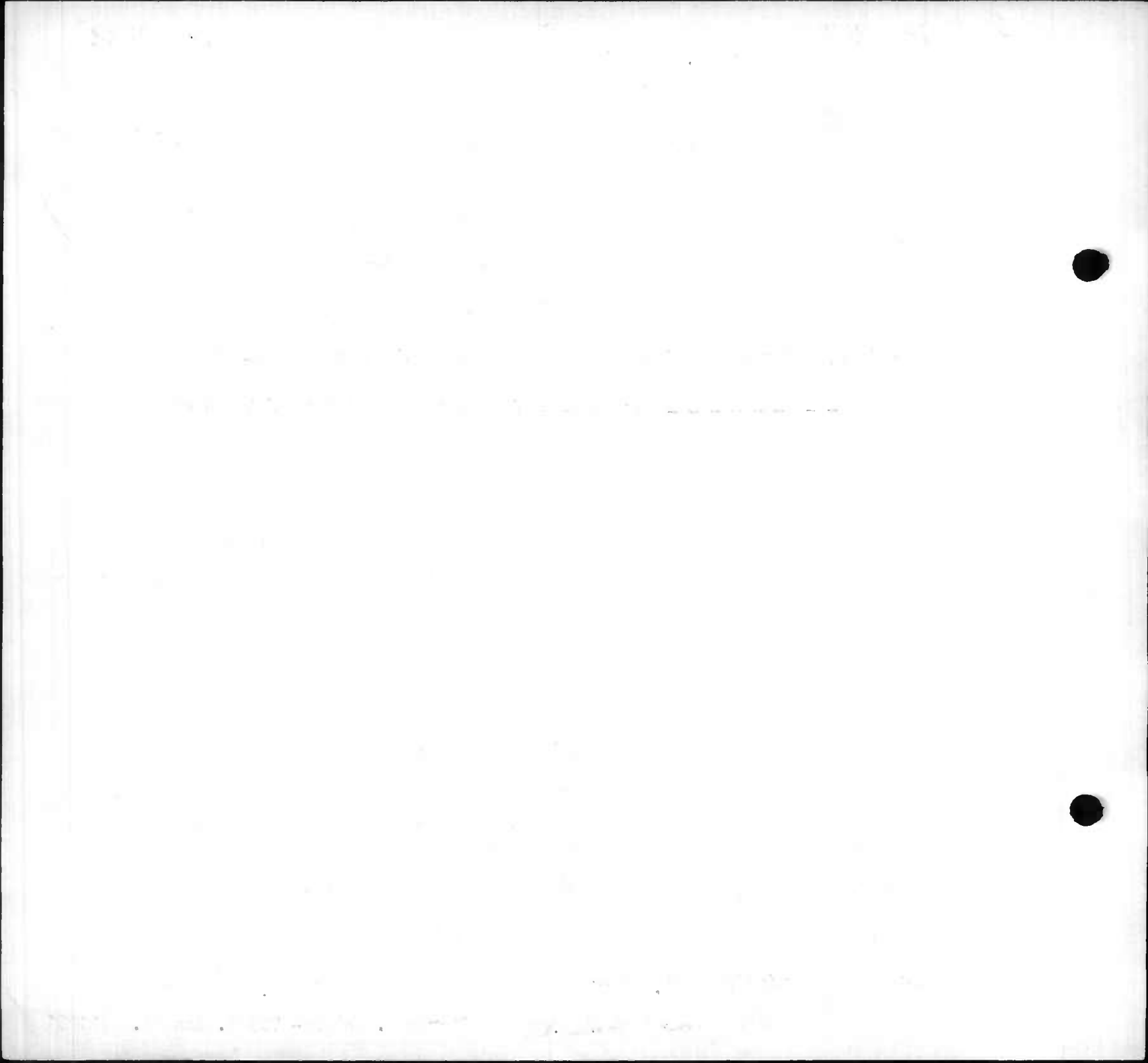
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02631	
M-653 72 02631				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Geneva Morant		13 th March 1972 11:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
University of Maryland Hospital			Maryland		
38			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1611 West Lanvale St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (last birthday)	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
female	Negro		24 Dec. 1912	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cook		School Cafeteria		South Carolina	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Julius Graham			Cornelia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs Mattie Frazier, Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
15391			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: lelomyosarcoma of the bowel with generalized metastases		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 19 to 13 th March 1972, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 13 th March 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Raymond E. Knowles Jr. MD				13 th March 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Raymond E. Knowles, Jr. MD				University of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3/19/72		Goodmans Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				South Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 15 1972		Robert E. Frazier, MD		Adolphus Halstead 1206 W 4 th North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

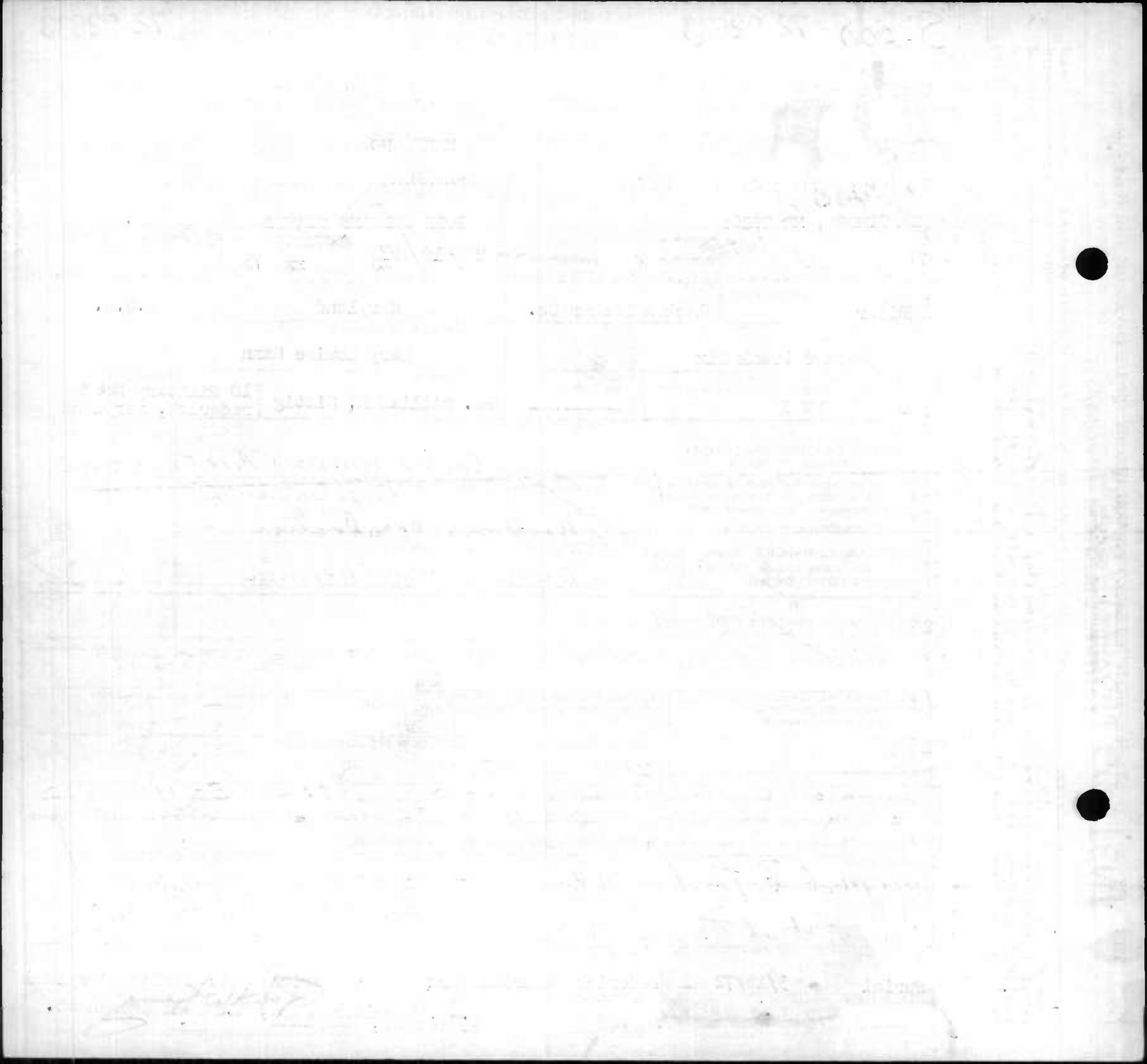
72 02632		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02632	
BIRTH NO. 72 02632		Theodore P. Barczak				2. DATE AND HOUR OF DEATH 3/15/72 2:30 A	
1. NAME OF DECEASED (Type or Print) THEODORE P. BARCZAK		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MARYLAND GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE #21205	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 903 N. Linwood AVE. 701	
5. SEX ♂ M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 3-1906	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO ASSEMBLY		10B. KIND OF BUSINESS OR INDUSTRY CHEVY.		11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JACOB BARCZAK				14. MOTHER'S MAIDEN NAME WALERJA CZAJA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-4536		17. INFORMANT ADDRESS ANNA SEAMAN 903 N. LINWOOD AVE			
18. 573.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:		years			
		(C) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF:		years			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Net While <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/11/72 to March 15 1972 that (I) (we) last saw the deceased alive on March 15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael A. Silverman M.D.				23B. DATE SIGNED 3/15/72			
23C. PHYSICIAN'S NAME (Type) Michael A. Silverman M.D.				23D. ADDRESS Maryland Gen Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS George A. Weber - 705 S. Ann St. #21231			



EXAMINER'S OFFICE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

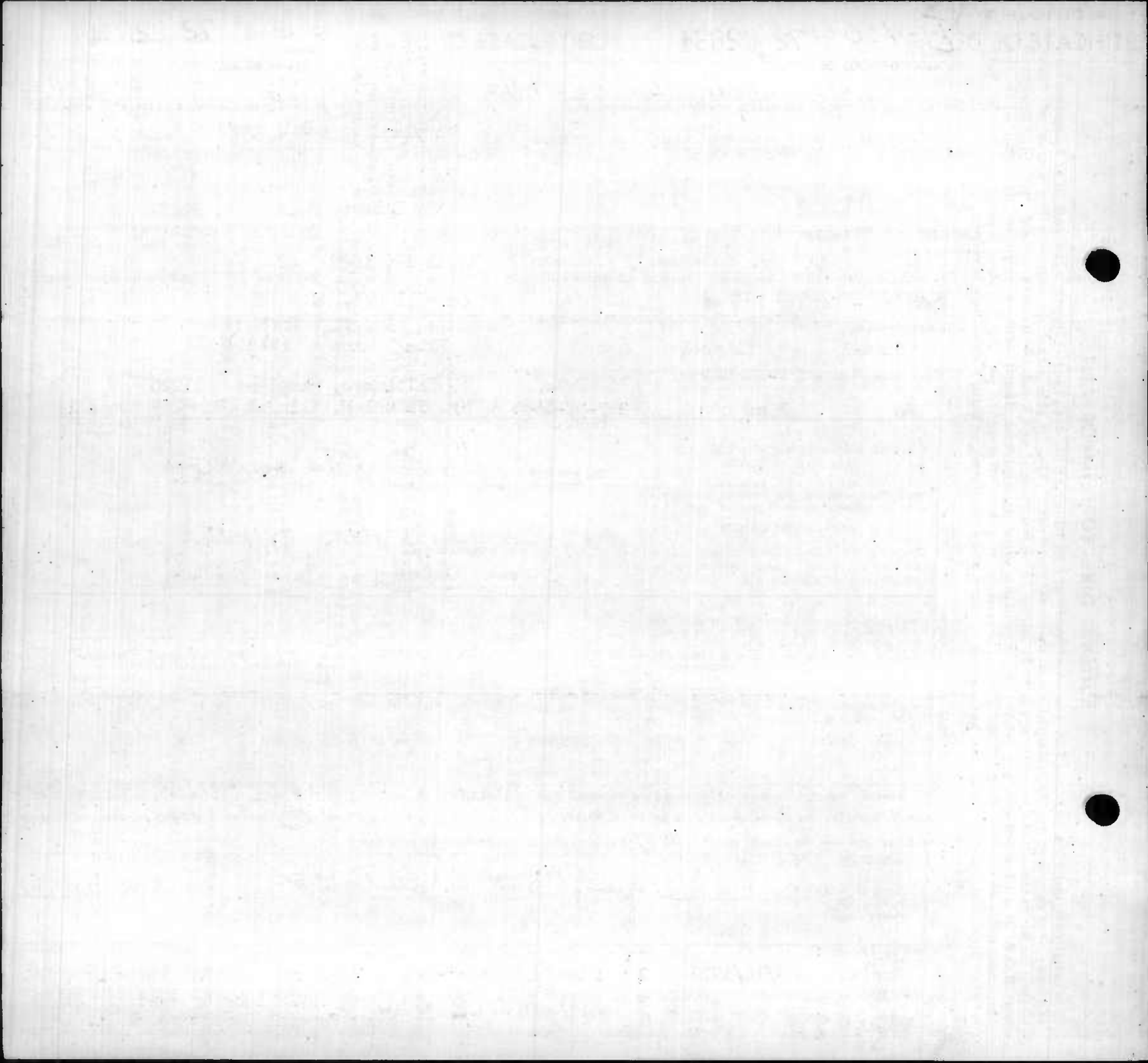
S-200 72 02633		BIRTH NO.		DEATH NO.		REG. NO. 72 02633	
1. NAME OF DECEASED (Type or Print) Charles Leo Six				2. DATE AND HOUR OF DEATH 3/11/72 1:12 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hosp. BALTIMORE, MD 21205				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 604 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2022 ORLEANS STREET			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/97	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10B. KIND OF BUSINESS OR INDUSTRY Black & Decker Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Frank Six				14. MOTHER'S MAIDEN NAME Mary Louise Hann			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. William E. Sittig		ADDRESS 510 Military Road Frederick, Maryland	
18. 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: Cause unknown (B) Acidosis, Dehydration DUE TO, OR AS A CONSEQUENCE OF: (C) Exposure + Hypothermia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 mi							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3-10-1972 to 3-11-1972 that (2) (we) lost saw the deceased alive on 3-11-1972 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Michael Tucker M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/11/72	
23C. PHYSICIAN'S NAME (Type) W. Michael Tucker M.D.				23D. ADDRESS Box 83 Johns Hopkins Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/72		24C. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		24D. LOCATION (City, town, or county) (State) Frederick Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR M. R. Etchison & Son, 106 East Church St. Frederick, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02634	
E-400 72 02634 BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Elizabeth Louise Ely				2. DATE AND HOUR OF DEATH 3-11-72 2:25 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6300 Liberty Road		21207	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 19, 1889	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bendix Friez				11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Klingel				14. MOTHER'S MAIDEN NAME Ella Ann (West)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. 217-07-5424		17. INFORMANT ADDRESS Baltimore, Maryland 21220 A Mr. Samuel H. Klingel Box 263 Route 16	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident (B) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic obstructive lung disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <input checked="" type="checkbox"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 4 19 72 to March 11 19 72 , that (I) (we) last saw the deceased alive on March 11 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Picoma & Joaquin MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED March 11, 1972	
23C. PHYSICIAN'S NAME (Type) Picoma & Joaquin				23D. ADDRESS 7000			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/14/1972		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Farber, MD		25C. FUNERAL DIRECTOR 7000		ADDRESS 8728 Liberty Road 21133 Loring Byers Funeral Directors, P. A.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652		72 02635		BALTIMORE CITY HEALTH DEPARTMENT		72 02635	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Ruby Elizabeth Burns</i>				2. DATE AND HOUR OF DEATH <i>Mar 12, 1972 4:10 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Frederick</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> <i>38</i>				C. CITY OR TOWN <i>Thurmont, Md.</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER							
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23, 1918</i>	9. AGE (in years last birthday) <i>53</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocery store owner</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Groceries</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Oliver B. Baker</i>				14. MOTHER'S MAIDEN NAME <i>Nellie Davis</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>24-10-4292</i>		17. INFORMANT <i>Darryl + Dennis Burns</i>		ADDRESS <i>Rt. #2 Thurmont, Md.</i>	
18. <i>188X I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Squamous Cell Car of the Bladder 1-26-72-11 Mar 72</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>1-26-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of the Bladder</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>none</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>none</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <i>None</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>Jan 26, 1972</i> to <i>March 11, 1972</i> that (1) (we) lost saw the deceased alive on <i>Mar 11, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>H.E. Bondy</i>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>H.E. Bondy</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>3-16-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Frederick Fred. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1972</i>		25B. NAME OF REGISTRAR <i>R. E. E. E. E.</i>		25C. FUNERAL DIRECTOR <i>Raymond E. Creager</i>		ADDRESS <i>Thurmont, Md.</i>	

SI - 10 -

Hydrographic

REG. NO.

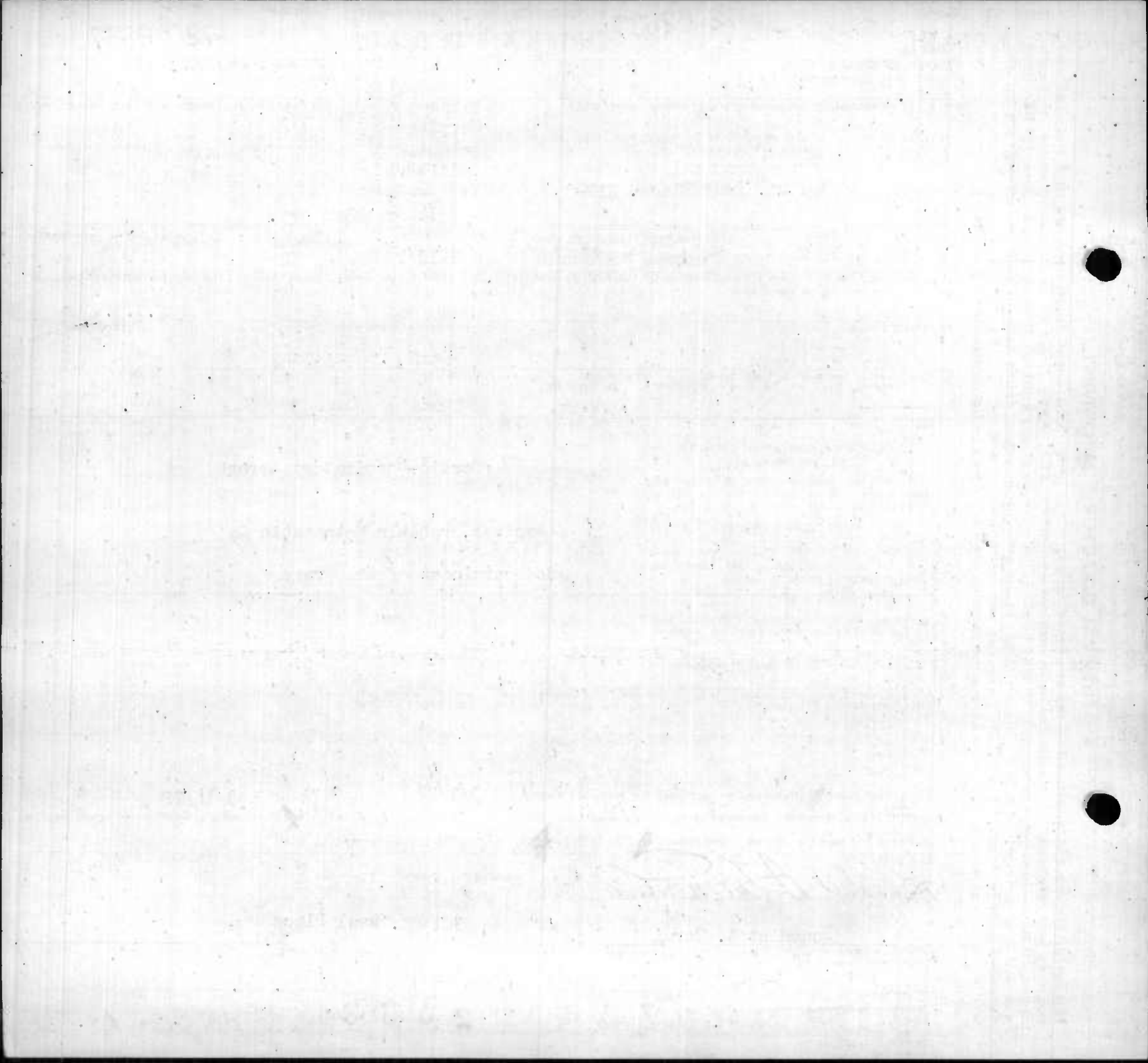
VS 151-REV. 1/1/6B

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02637
BIRTH NO. 4-400		72 02637 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Margaret Hill		2. DATE AND HOUR OF DEATH 3/14/72 1:20 P. <small>M.</small>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital 301 St. Paul Place. 21202		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2544 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 6. STREET AND NUMBER 3914 Brooklyn Ave.		
7. SEX F	8. RACE W	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) 72
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.
14. FATHER'S NAME Joseph A. Snyder		15. MOTHER'S MAIDEN NAME Sarah C. Macilhenny		
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		17. SOCIAL SECURITY NO. unknown		
18. WITNESSES (If yes, give names and addresses) unknown		19. INFORMANT ADDRESS Dolores Harrison 3914 Brooklyn Ave.		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE Cardio-Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Ascites, Probable Metastatic Ca DUE TO, OR AS A CONSEQUENCE OF: (C) Adenocarcinoma of the Ovary				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 3/18/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21B. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work		
22. I certify that (A) (this hospital) attended the deceased from 3/2/72 19 72 to 3/14/72 19 , that (B) (we) last saw the deceased alive on 3/14/72 19 and that in (C) (our) opinion death occurred on the date 3/14/72 19 and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
23A. SIGNATURE Benedict A. Termini		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Benedict A. Termini		23D. ADDRESS 301 St. Paul Place		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72		
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Balta, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR 2544		
25D. ADDRESS 130 E. Fort Ave. 21230		25E. ADDRESS 130 E. Fort Ave. 21230		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02638		72 02638	
<p>S-361</p> <p>BIRTH NO. 72 02638</p> <p>CERTIFICATE OF DEATH</p>				<p>REG. NO. 72 02638</p>			
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">GEORGE ERNEST STRAUB</p>				<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">MARCH 13, 1972 6:00 A.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>40 St. Agnes Hospital</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 5 Overbrook Rd.</p>			
<p>5. SEX Male</p>		<p>6. RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Jan. 7, 1900</p>	
<p>9. AGE (In years last birthday) 72</p>		<p>If Under 1 Yr. Months Days</p>		<p>If Under 24 Hrs. Hours Min.</p>			
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Engineer</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>Monitor Controller</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>	
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>							
<p>13. FATHER'S NAME Francis George Straub</p>				<p>14. MOTHER'S MAIDEN NAME Emma Doenges</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>Yes WW I</p>		<p>16. SOCIAL SECURITY NO. 214 01 5248</p>		<p>17. INFORMANT Mrs. Marguerite Borchers</p>		<p>ADDRESS Same</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>myocardial infarction</p>				<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE myocardial infarction</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk.</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>Chronic Myocarditis</p>				<p>(B) Chronic Myocarditis</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>5 yrs</p>	
<p>(C) Arteriosclerotic C.V.R. disease</p>				<p>5 yrs</p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 7-15-1971 to 3-13-1972 that (I) (we) last saw the deceased alive on 3-11-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>							
<p>23A. SIGNATURE Wilmer K. Gallagher, Sr. M.D.</p>				<p>23B. DATE SIGNED 3-13-72</p>			
<p>23C. PHYSICIAN'S NAME (Type) Dr. Wilmer K. Gallagher, Sr.</p>				<p>23D. ADDRESS 6209 Frederick Ave. Baltimore, Md.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3/16/72</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Western</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972</p>		<p>25B. NAME OF REGISTRAR Edw. S. MacNabb</p>		<p>25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons, Inc.</p>		<p>ADDRESS 301 Frederick Rd. Catonsville, Md.</p>	

1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-322 72 02639				BALTIMORE CITY HEALTH DEPARTMENT		72 02639	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) CHARLES MATOUSEK				2. DATE AND HOUR OF DEATH 3/14/72 3³² A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 702 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 815 N. Montford Avenue			
5. SEX Male	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/1881	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Mad. & Bradford		11. BIRTHPLACE (State or foreign country) Czech.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-01-9775		17. INFORMANT ADDRESS Helen Carmody (dghtr) 7610 Park Grove Rd.			
18. 450X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which directly led to death.) Pulmonary embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, leading rise to the above cause and forming the UNDERLYING CONDITION last Persistent GI bleeding; pneumonia				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 20 mins (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 1 wk.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 28 19 72 to March 14 19 72 that (I) (we) last saw the deceased alive on March 14 19 72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Penelope P. Scott, M.D.				23B. DATE SIGNED 3/14/72		23C. PHYSICIAN'S NAME (Type) PENELOPE SCOTT, M.D.	
23D. ADDRESS JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/15/72		24C. NAME OF CEMETERY OR CREMATORY Bohemian Nat'l Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR 2000		25C. FUNERAL DIRECTOR Schumnek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	

THE STATE OF NEW YORK
IN SENATE
January 10, 1907.

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906.

ALBANY: JAMES B. LEECH, STATE PRINTER.
1907.

ALBANY: JAMES B. LEECH, STATE PRINTER.
1907.

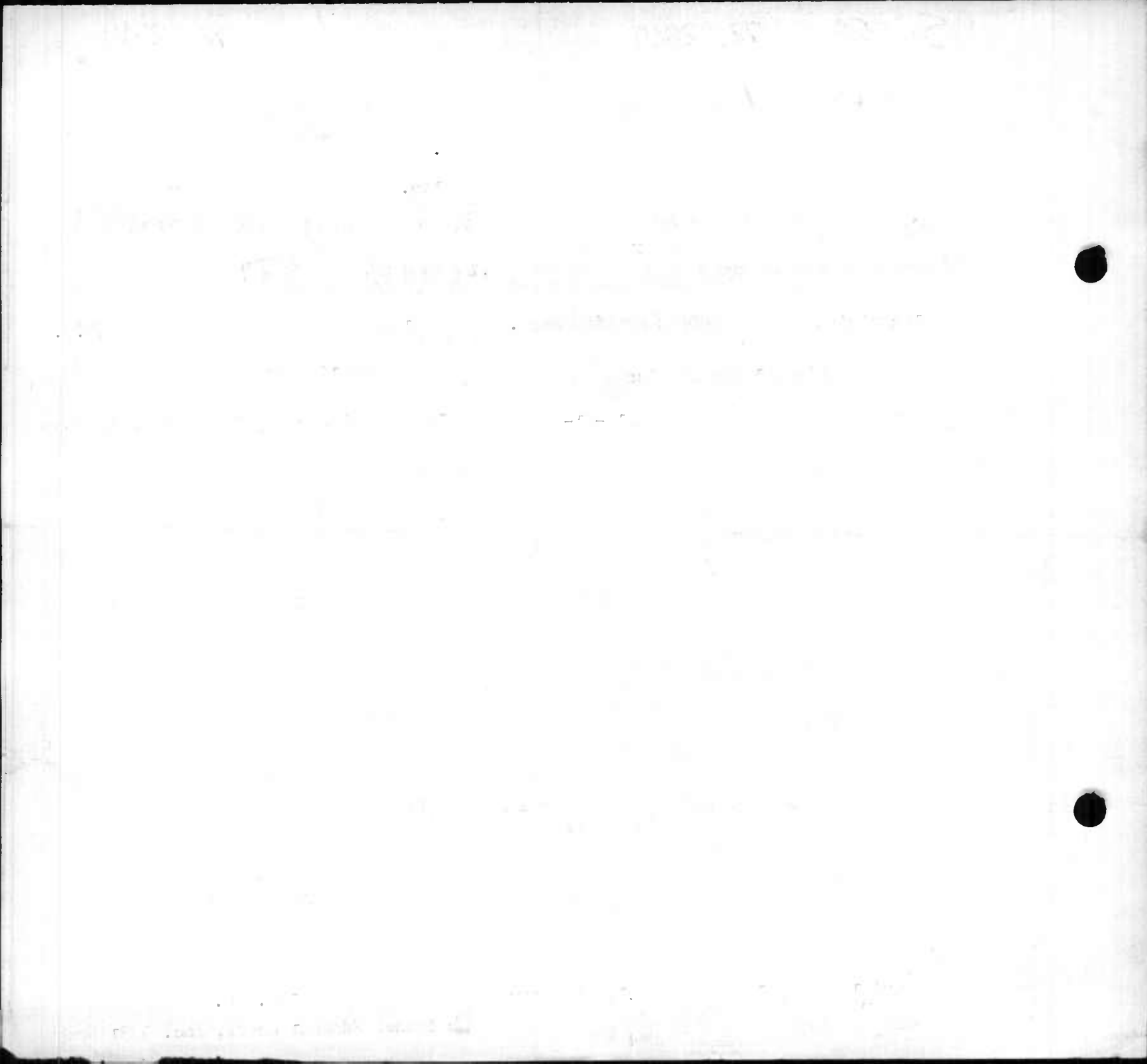
ALBANY: JAMES B. LEECH, STATE PRINTER.
1907.

ALBANY: JAMES B. LEECH, STATE PRINTER.
1907.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>5-352 72 02640 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02640</p>	
<p>BIRTH NO. 5-352</p>		<p>1. NAME OF DECEASED (Type or Print) STEVEN STANKIEWICZ</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>2. DATE AND HOUR OF DEATH MARCH 12, 1972 1 330 A. M.</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC.</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2643</p>	
<p>5. SEX MALE 6. RACE CAUCASIAN</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician</p>		<p>8. DATE OF BIRTH 12/25/04 9. AGE (In years last birthday) 67</p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hosp.</p>		<p>11. BIRTHPLACE (State or foreign country) Poland</p>	
<p>13. FATHER'S NAME Michael Stankiewicz</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>		<p>14. MOTHER'S MAIDEN NAME Rozalia Furman</p>	
<p>16. SOCIAL SECURITY NO. 213-01-8556</p>		<p>17. INFORMANT Helen Stankiewicz (wife)</p>	
<p>18. CAUSE OF DEATH 157.91</p>		<p>ADDRESS same as above</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PANCREATITIS</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BILATERAL PLEURAL EFFUSION</p>		<p>19 days</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CARCINOMA OF THE PANCREAS</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —</p>	
<p>20A. AUTOPSY? (Yes or No) —</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? —</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 2/23/72 19__ to 19 19__ that (I) (we) last saw the deceased alive on March 12 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE [Signature]</p>		<p>23B. DATE SIGNED MARCH 12, 1972</p>	
<p>23C. PHYSICIAN'S NAME (Type) DANIEL W. MIRELMAN M.D.</p>		<p>23D. ADDRESS SINAI HOSPITAL OF BALTIMORE</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3/15/72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer</p>		<p>24D. LOCATION (City, town, or county) (State) Balto. Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972</p>		<p>25B. NAME OF REGISTRAR [Signature]</p>	
<p>25C. FUNERAL DIRECTOR Schmunek Funeral Homes, Inc.</p>		<p>ADDRESS 3331 Brehms Lane, Balto. Md.</p>	



R-340

72 02641 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02641

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) GUSTAV F. RIDDELL GUS RIDDELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 127 S. Schroeder St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 13 1972 8:10 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/7/1910		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		14B. KIND OF BUSINESS OR INDUSTRY Coppers Co.	
15. MOTHER'S MAIDEN NAME Margaret Hopwood		16. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II	
17. SOCIAL SECURITY NO. 217-07-1746		18. INFORMANT Mary Casey 1931	
19. CAUSE OF DEATH Active pulmonary tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3/15/72	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Balto., Ind.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR James E. Conner		ADDRESS Ind. Inc. 901 Hollins St. Balt., 21223	

Get me

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Manfred Keller				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 13 72 1:26 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 13 72 1:26 P.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 52 Anne Arundel				6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH Nov. 27, 1908 10. AGE (In years last birthday) 63 11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Keller				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter			
15. MOTHER'S MAIDEN NAME (unknown)				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			
17. SOCIAL SECURITY NO. 171/03/3750				18. INFORMANT ADDRESS Mrs. Viola L. Keller (wife) same as #5			
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 3/17/72				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner H. Spitz, M.D. DATE SIGNED 3-14-72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/17/72			
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park				24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972				25B. NAME OF REGISTRAR Robert E. Fisher			
25C. FUNERAL DIRECTOR Singleton Funeral Home				ADDRESS Glen Burnie, Md.			

Page 11

UNITED STATES DEPARTMENT OF JUSTICE

February 2, 1954

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D. C.

Dear Mr. Hoover:

Reference is made to your letter of January 28, 1954, regarding the above captioned matter.

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

W. J. Donovan, Jr., Attorney General

Enclosure

Very truly yours,
W. J. Donovan, Jr., Attorney General

Enclosure

W. J. Donovan, Jr., Attorney General

Enclosure

W. J. Donovan, Jr., Attorney General

Enclosure

W. J. Donovan, Jr., Attorney General

Enclosure

W. J. Donovan, Jr., Attorney General

Enclosure

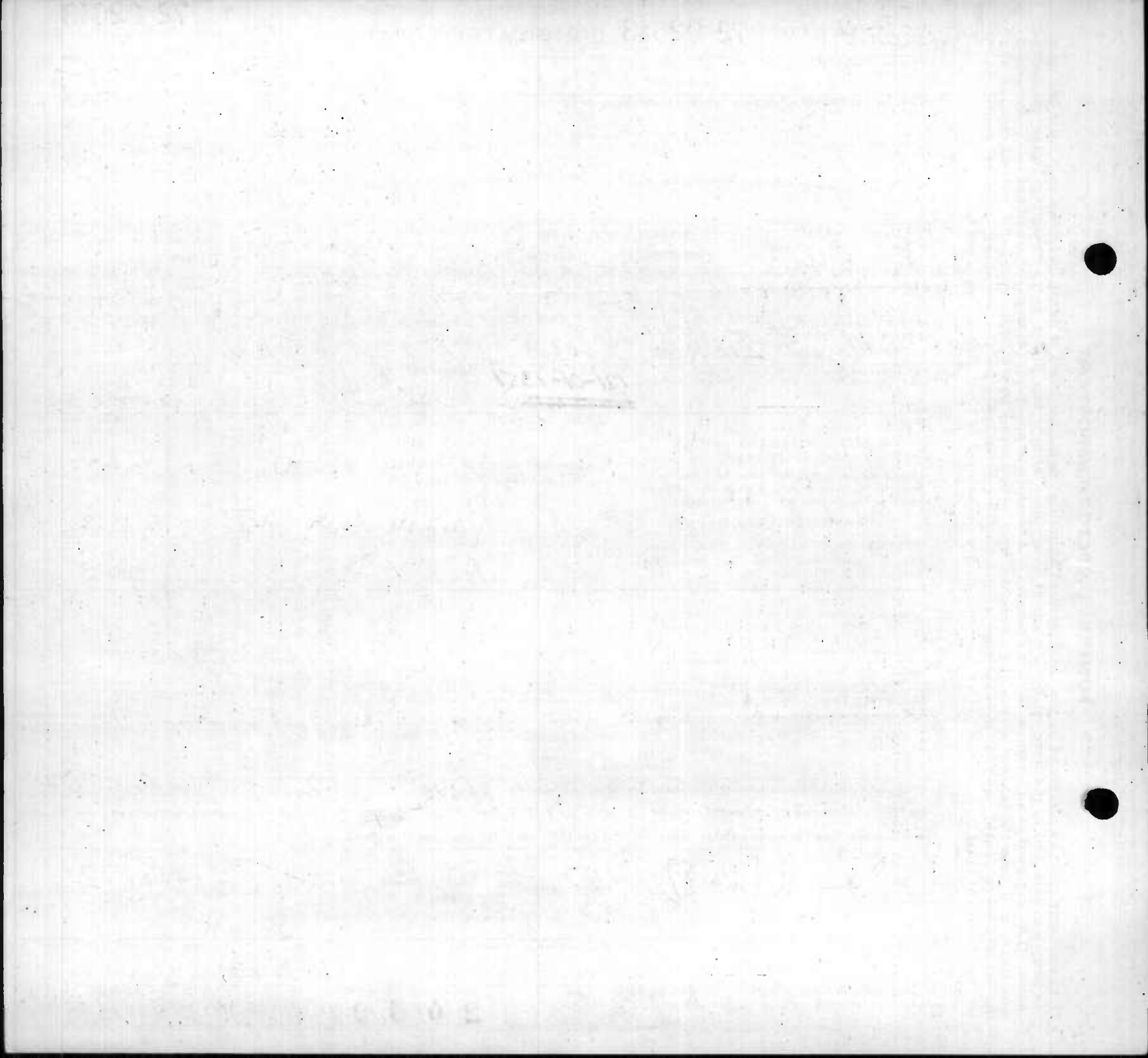
W. J. Donovan, Jr., Attorney General

Enclosure

W. J. Donovan, Jr., Attorney General

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

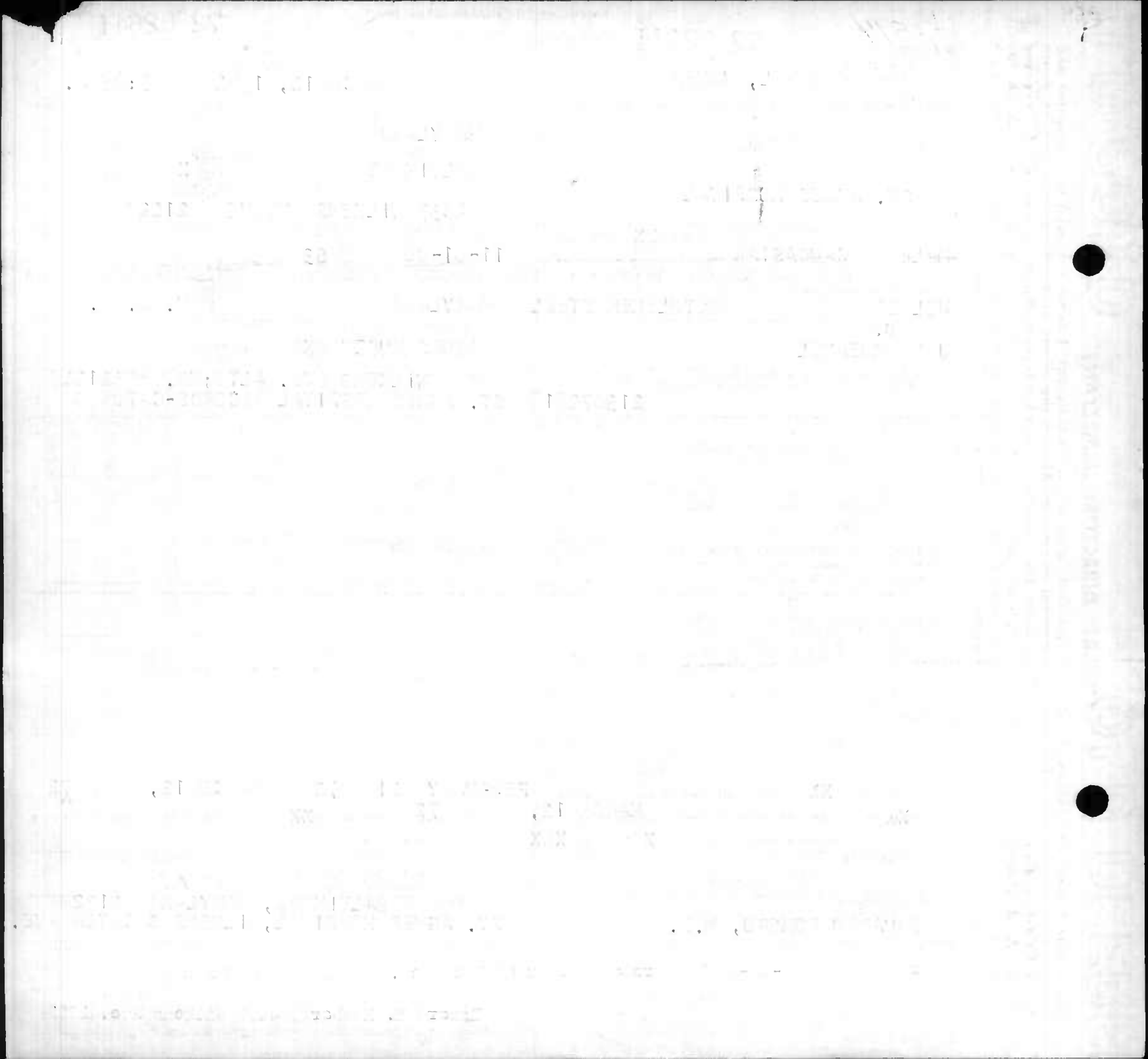
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

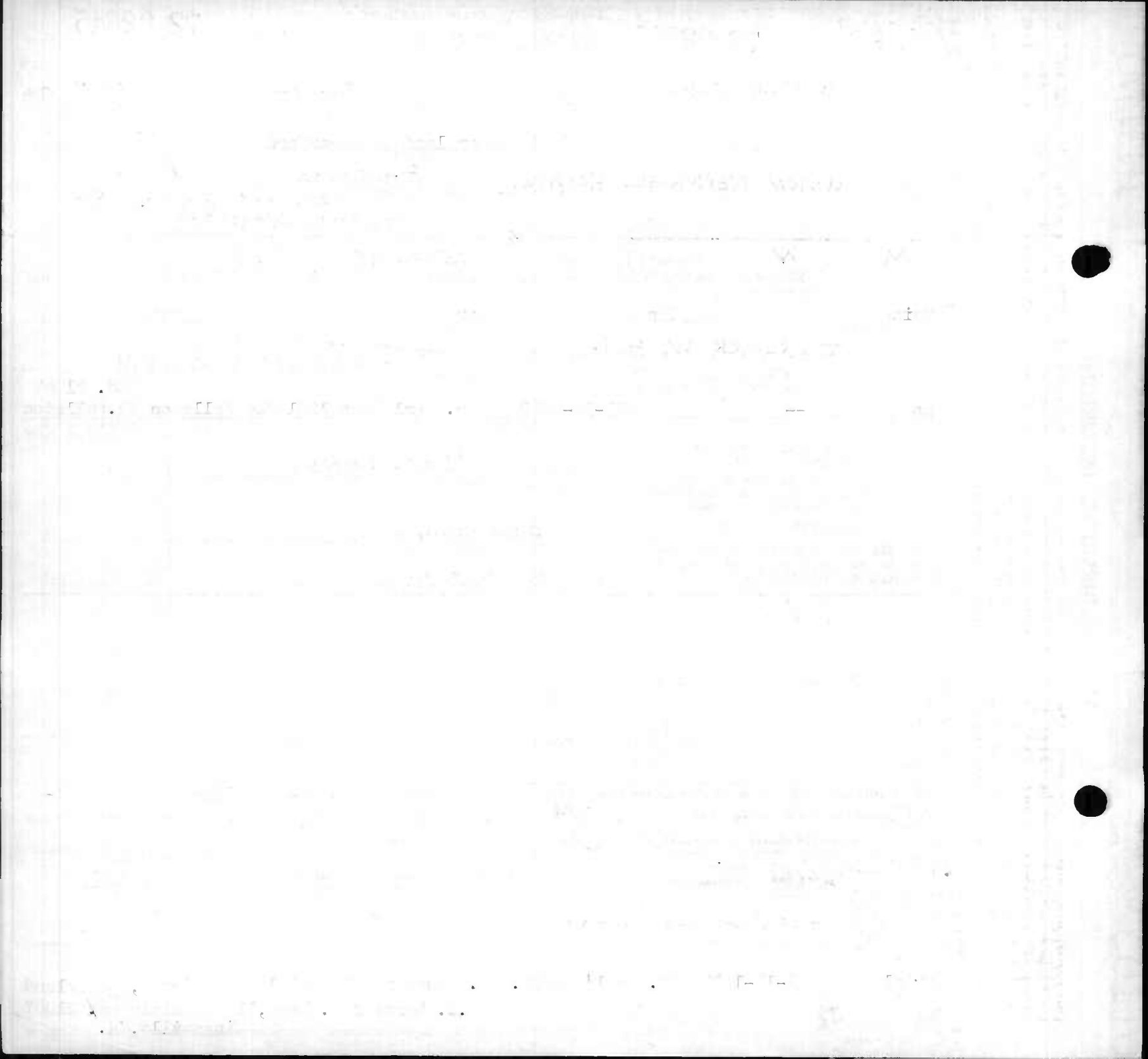
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02644	
K-514 72 02644		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KNEAVEL, JAMES		2. DATE AND HOUR OF DEATH MARCH 12, 1972 3:45 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2551 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4037 WILKENS AVENUE 21229			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-01-08	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN KNEAVEL			
14. MOTHER'S MAIDEN NAME AGNES WILKINSKA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 213072818		17. INFORMANT WILKENS AVE. BALTO; MD. ADDRESS 21229 ST. AGNES HOSPITAL RECORDS-CATON &			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>metastasis from unknown primary malignancy.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>month (Several)</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 21 1972 to MARCH 12, 1972 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MARCH 12, 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <i>E. G. Romero MD</i>		23B. DATE SIGNED 3/12/72		23C. PHYSICIAN'S NAME (Type) EDUARDO ROMERO, M.D.	
23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL, WILKENS & CATON AVE.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3-15-1972		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR <i>Robert L. Fisher, Jr.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

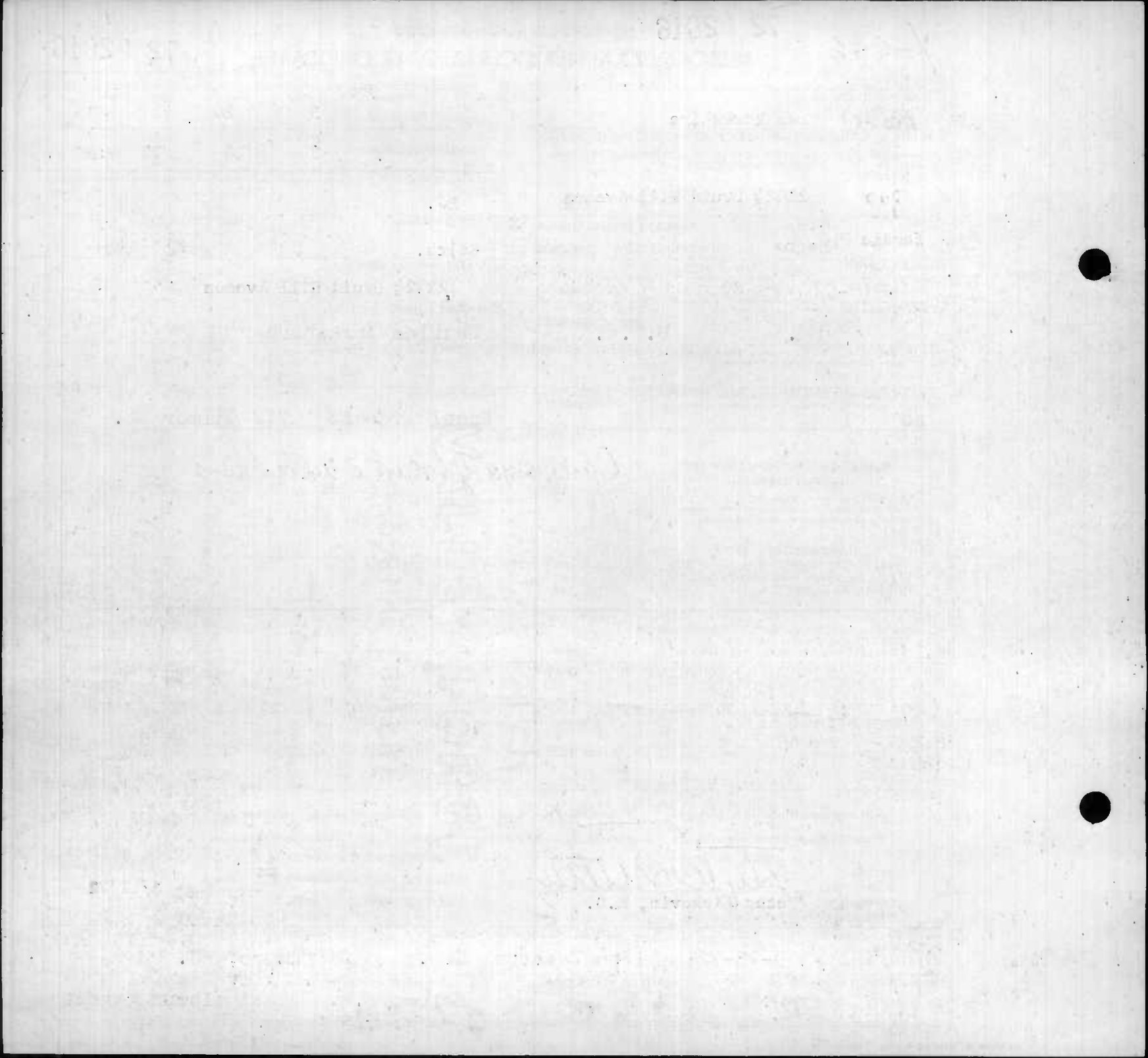
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 72 02645 BALTIMORE CITY HEALTH DEPARTMENT				X		72 02645	
BIRTH NO.				REG. NO.		72 02645	
1. NAME OF DECEASED (Type or Print) William Bode				2. DATE AND HOUR OF DEATH 3/14/72 8:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1201 Old Fallston Rd. Fallston, MARYLAND			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-24-10		9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10B. KIND OF BUSINESS OR INDUSTRY Own		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany
13. FATHER'S NAME Frederick W. Bode,				14. MOTHER'S MAIDEN NAME KAROLINE BLUM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-36-0069		17. INFORMANT Mr. Carl Bode 1201 Old Fallston Rd. Fallston Md. 21047			
18. 209X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myelofibrosis. pneumonia. splenectomy.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/3/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FAIR		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/9 19 72 to 3/14 19 72 the (I) (we) lost saw the deceased alive on 3/14 19 72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Tzen-chi Fan-chiang				23B. DATE SIGNED 3/14/72		23C. PHYSICIAN'S NAME (Type) TZEN-CHI FAN-CHIANG	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-1972		24C. NAME of CEMETERY or CREMATORY St. Paul's Luth. Ch. Cemetery Kingsville Baltimore, Maryland		24D. LOCATION (City, town, or county) (State) BALTIMORE/MD 21218	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR E. J. Lassahn		25C. FUNERAL DIRECTOR E. J. Lassahn F. Home, 11750 Belair Rd., 21087 Kingsville, Md.			



1

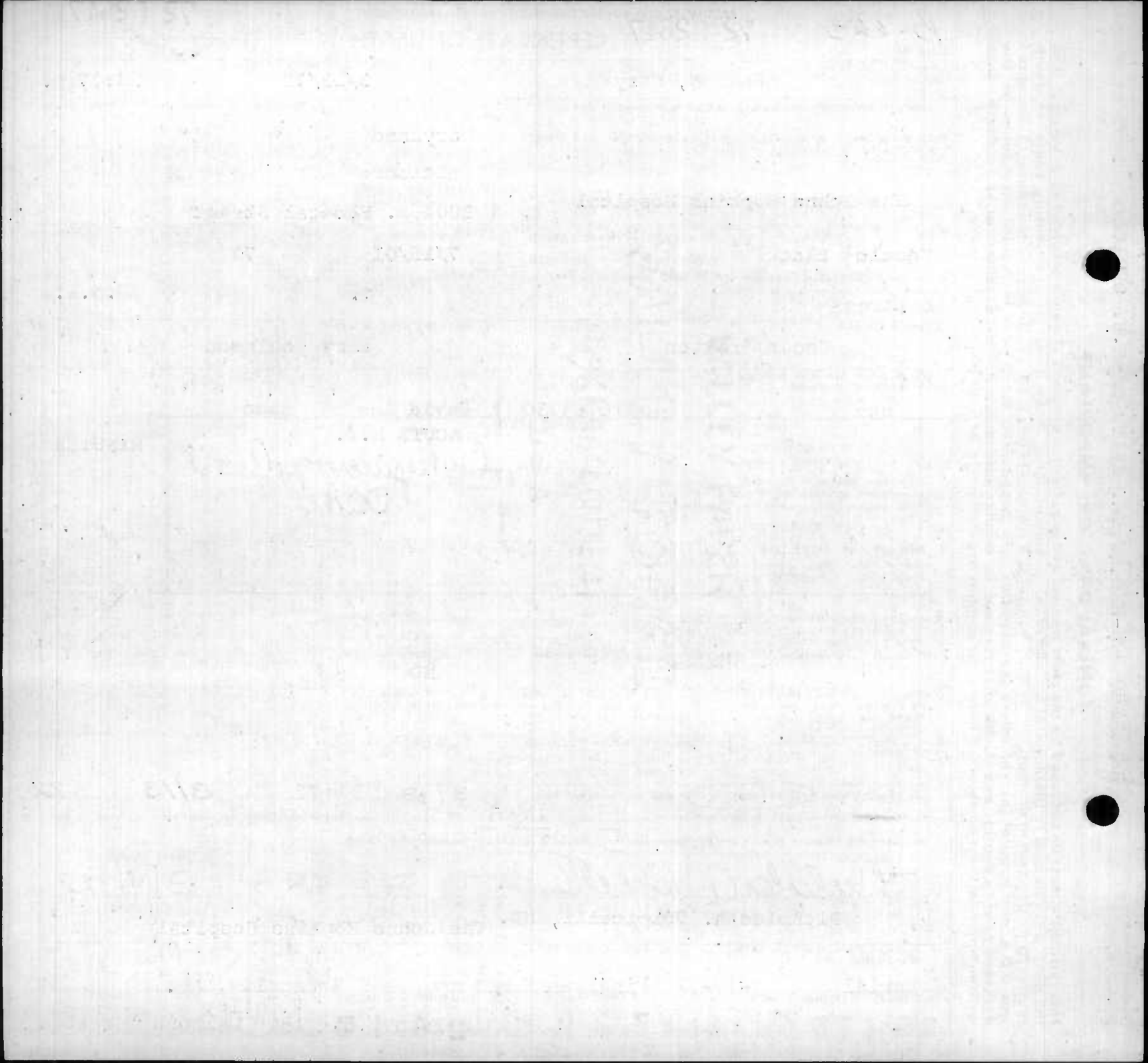
72 02646		BALTIMORE CITY HEALTH DEPARTMENT		72 02646	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Rosie</i> Rosa Yorkshire			2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 10 Year 72 Hour M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00</i> 2242½ Druid Hill Avenue			3. DATE PRONOUNCED DEAD Month 3 Day 10 Year 72 Hour 4:02 p. M.		
6. SEX female			7. RACE Negro		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN Balto.		
9. DATE OF BIRTH 5-16-91			10. AGE (In years last birthday) 80		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			14B. KIND OF BUSINESS OR INDUSTRY		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			17. SOCIAL SECURITY NO.		
18. INFORMANT Hazel Everett			ADDRESS 712 Gilmore St.		
19. <i>174X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH <i>Carcinoma of breast - metastases</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
20A. DATE OF OPERATION <i>0</i>			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22F. HOW DID INJURY OCCUR?			22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/11/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR <i>John S. [illegible]</i>		25C. FUNERAL DIRECTOR V. Bailey ADDRESS Kelson F.H. 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

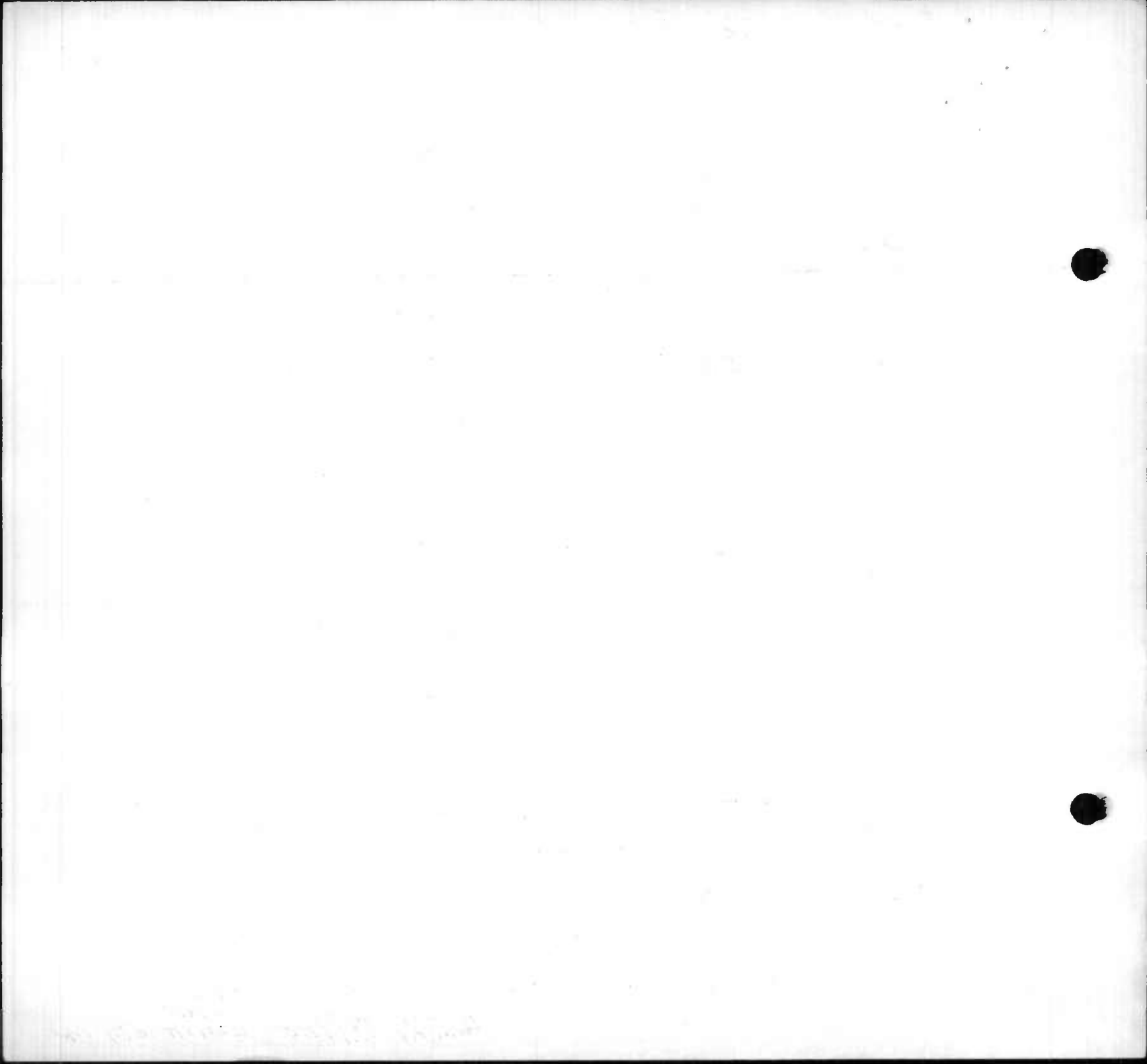
Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02647	
B-623 72 02647				CERTIFICATE OF DEATH			
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BRAXTON, Mary		3/13/72 4:07 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 33 79 The Johns Hopkins Hospital				Maryland		802	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3004 E. Federal Street			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days	11. UNDER 24 Hrs. Hours Min.	
Female	Black	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7/15/01	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seamstress						Va.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.				Oscar Braxton		Mary Robinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				216183730		David Lee same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
4/10/72 I				ACUTE M.I.			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		Cardiopulmonary Arrest. DCA.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0						NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/13 1972 to 3/13 1972, that (I) (we) last saw the deceased alive on PT DCA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Nicholas A. Volpicelli, MD.				3/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				3-17-72		Pinelawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 16 1972				V. ailey		1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

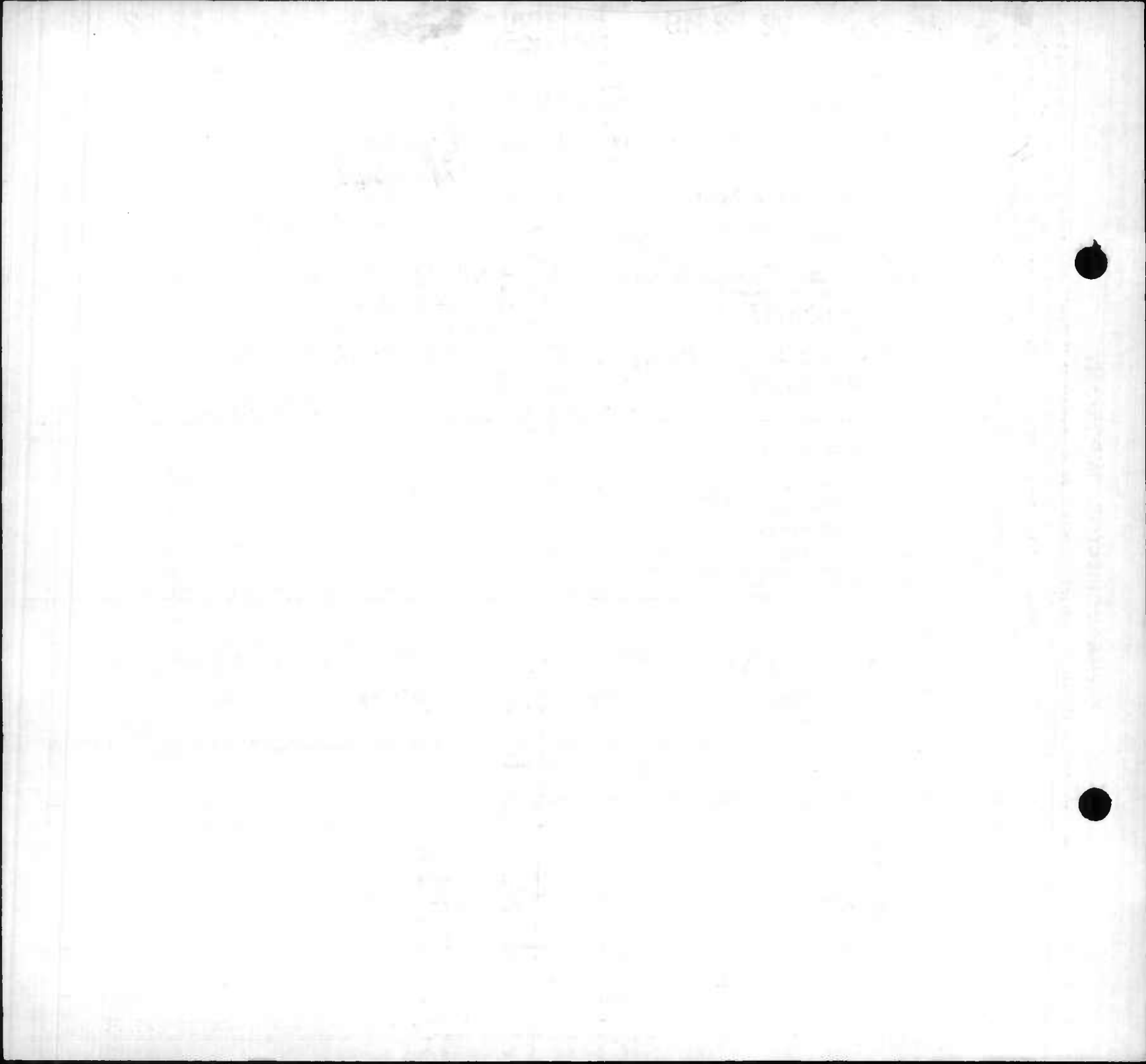
E-430		72 02648		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02648	
1. NAME OF DECEASED (Type or Print) ANNIE ELLIOTT				2. DATE AND HOUR OF DEATH 3/11/72 5:40 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1801					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 GOULD CONVALESCARIUM 6116 BELAIR ROAD BALTO., MD. 21206				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 913 W. FRANKLIN ST.					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH DEC. 27, 1901	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST NIEBEL				14. MOTHER'S MAIDEN NAME ELIZABETH					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-54-3108		17. INFORMANT ADDRESS GOULD CONVALESCARIUM 6116 BELAIR RD			
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterior Myocardial Infarction				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: yes					
(C) _____									
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Congestive Heart Failure; Old Stroke				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10/9/1970 to 3/11/1972 that (I) (we) last saw the deceased alive on 2/10/1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE Albert B. Bradley				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/12/72			
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY MD.				23D. ADDRESS 4900 BELAIR RD BALTIMORE 21206 MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 3/13/72		24C. NAME OF CEMETERY OR CREMATORY LODGE PARK		24D. LOCATION (City, town, or county) (State) BALTO. MD			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR NEWMAN SECURITY FIN. HOME ADDRESS HARRY WITKE BALTIMORE CITY MD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

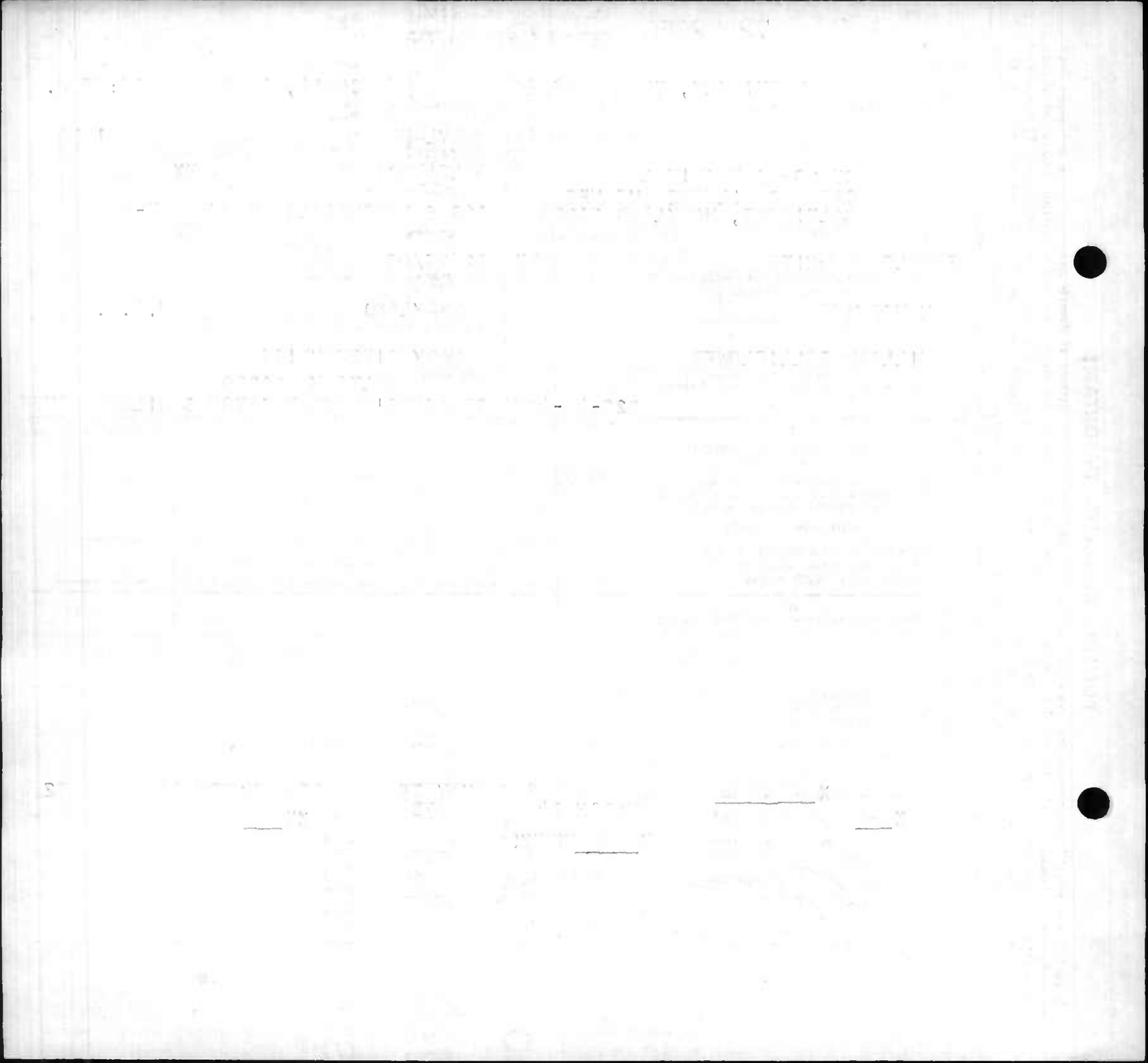
B-620 72 02649		BALTIMORE CITY HEALTH DEPARTMENT		T		72 02649	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) (Frederick) GEORGE BAUEREIS		2. DATE AND HOUR OF DEATH March 15 72 4:10 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN WOODLAWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2311 POPLAR DRIVE - 21207					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08-14-01		9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME MICHAEL BAUEREIS				14. MOTHER'S MAIDEN NAME MARGARET HUEF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-32-8883		17. INFORMANT PULLINE BAUEREIS		ADDRESS SAHE	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYO CARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-13-72 to 3-15-72 that (I) (we) last saw the deceased alive on 3-15-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Juan M. Calderon				23B. DATE SIGNED 3-15-72			
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON MD.		23D. ADDRESS UHH					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR W. S. E. Taylor, MD.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue		ADDRESS 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>M-352 72 02650</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02650</p>	
<p>1. NAME OF DECEASED (Type or Print) MATTINGLY, THELMA AGNES</p>		<p>2. DATE AND HOUR OF DEATH MARCH 14, 1972 10:00 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2864 21229</p>	
<p>5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH 12/25/05 9. AGE (In years last birthday) 66</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>		<p>11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME WILLIAM COLLIFLOWER</p>		<p>14. MOTHER'S MAIDEN NAME MARY FITZMAURICE</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 220-48-4354 17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES RECORDS CATON & WILKENS AVES</p>	
<p>18. CAUSE OF DEATH</p> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>metastasis from abdominal tumor.</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 25 19 72 to MARCH 14 19 72 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 14 19 72 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (view) the body after death.</p>			
<p>23A. SIGNATURE <i>Eduardo Romera M.D.</i></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>Eduardo Romera</i></p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3/18/72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972</p>		<p>25B. NAME OF REGISTRAR <i>J. B. ...</i></p>	
<p>25C. FUNERAL DIRECTOR <i>Hitzke</i></p>		<p>ADDRESS 1630 Edmondson Avenue, 21228</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-163		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02651	
1. NAME OF DECEASED (Type or Print) SHEWBRIDGE, WILLIAM M			2. DATE AND HOUR OF DEATH MARCH 18 1972 7:20AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CO.		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE MARYLAND 21229			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 900 VANDERWOOD RD BALTO MD 21228					
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 14 90	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STEWARD			10B. KIND OF BUSINESS OR INDUSTRY RACING		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME WILLIAM SHEWBRIDGE			14. MOTHER'S MAIDEN NAME ANN (?) Kraus		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218015039		
17. INFORMATION WILKENS & CATON AVE. ST AGNES HSP. RECORDS			ADDRESS		
18. 410.9 + 185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis Cardiovascular Disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) Carcinoma of Prostate		
19A. DATE OF OPERATION 13-6-72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Prostate		
20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 1 1972 to MARCH 14 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 14 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE J. J. SADA			23B. DATE SIGNED 3/14/72		
23C. PHYSICIAN'S NAME (Type) JESADA			23D. ADDRESS St. Agnes Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) burial			24B. DATE 3/17/72		
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill			24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972			25B. NAME OF REGISTRAR Robert E. J. B. M.D.		
25C. FUNERAL DIRECTOR Witzke, 4637 Edmondson Avenue 21228			ADDRESS		

WILLIAM SHEWBRIDGE, WILLIAM M.
MARCH 12 1972

BALTIMORE MARYLAND 21229
900 VANDERWOOD RD BALTO MD 21229
BALTIMORE
BALTIMORE CO. MARYLAND

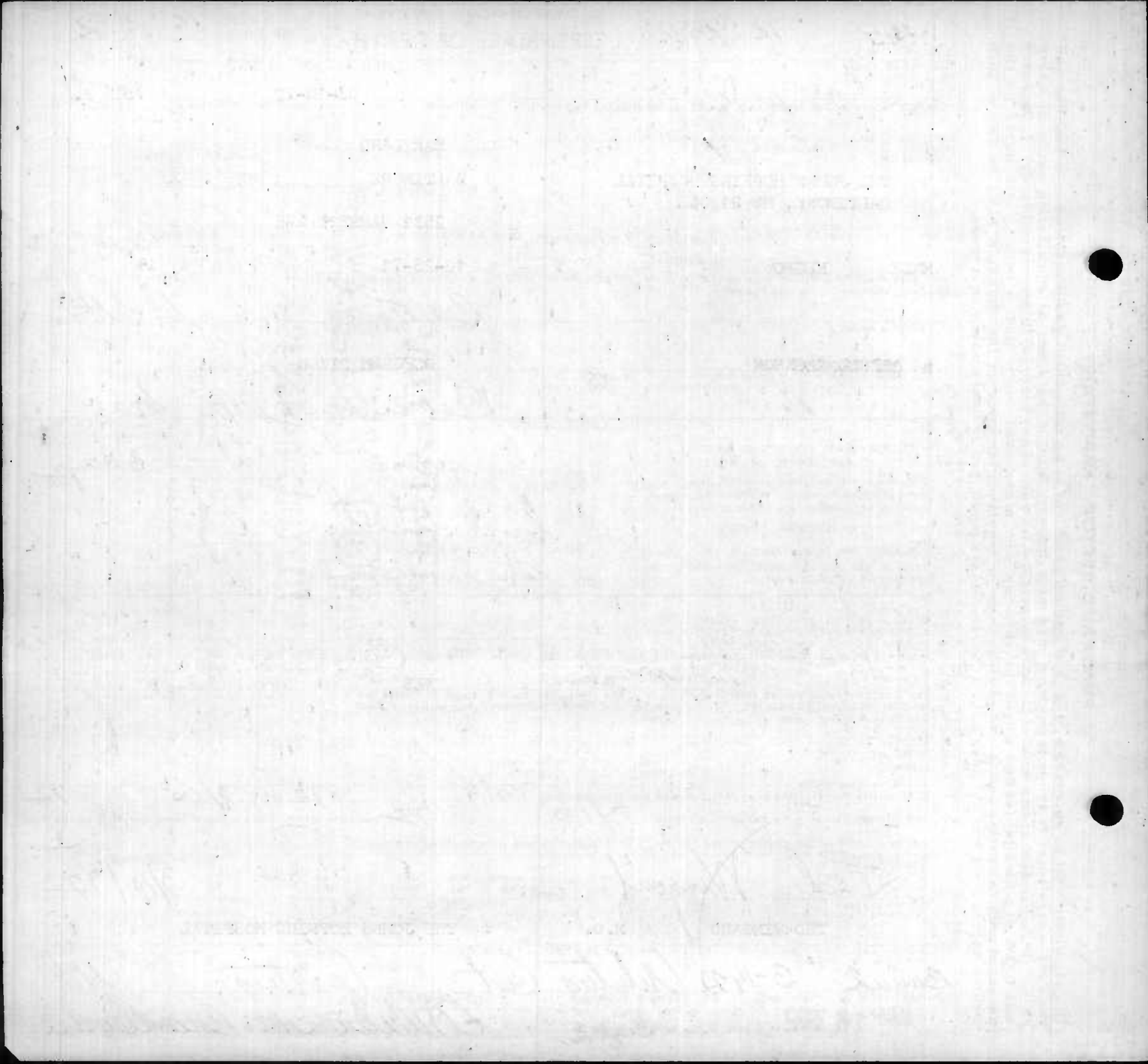
MALE CAUCASIAN
RETIRED STEWARD RACING
WILLIAM SHEWBRIDGE
MARCH 12 1972
ST AGNES HOSP RECORDS
WILKENS & CATON AVE
BALTIMORE MARYLAND
08 14 50
UNITED STATES

MARCH 12 1972
MARCH 12 1972
MARCH 12 1972

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02652	
CERTIFICATE OF DEATH				72 02652	
BIRTH NO. <u>D-250</u> <u>72 02652</u>		72 02652			
1. NAME OF DECEASED (Type or Print) <u>Corey Dixon</u>		2. DATE AND HOUR OF DEATH <u>03-10-72</u> <u>7:45 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>907</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2531 GARRETT AVE</u>					
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-71</u>	9. AGE (In years lost birthday) <u>4/2 months</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ARRELL JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>DEBORAH DIXON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Deborah Dixon</u>	
18. <u>560.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>sepsis</u> <u>bowel obstruction</u> <u>intussusception</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3/9</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>intussusception</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> 19 <u>72</u> to <u>3/10</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ted Wingard</u>		23B. DATE SIGNED <u>3/10/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>TED WINGARD</u> M.D.		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-14-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Whitman Crest</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Corbin, 000 Brantley Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520-1		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02653	
A-600		72 02653		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Thomas Aric</u>		2. DATE AND HOUR OF DEATH <u>3/11/72</u> <u>9:30</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>402</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>George Washington Nursing Home</u> <u>607 Pennsylvania Ave</u>		C. CITY OR TOWN <u>MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>710 West Saratoga St.</u>					
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1877</u>	9. AGE (In years last birthday) <u>93</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Hiran Murray</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-0300</u>		17. INFORMANT <u>Chart Datta W. Downey</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH <u>HYPERTENSIVE CARDIAC DISEASE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>DIABETES MELLITUS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>MARCH 3-</u> 19 <u>72</u> to <u>MARCH 11</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>MARCH 9-</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard Tyson, M.D.</u>		23B. DATE SIGNED <u>3-11-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard F. Tyson, M.D.</u>		23D. ADDRESS <u>936 W. North Avenue</u> <u>Baltimore, Maryland 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>3-16-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Antebellum</u>	
24D. LOCATION <u>City, town, or county</u> <u>MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltz, M.D.</u>		25C. FUNERAL DIRECTOR <u>Conklor, or Conklor, Inc.</u>	
25D. ADDRESS					

the wind blowing

۱۰۰

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-625		72 02654		72 02654	
1. NAME OF DECEASED (Type or Print) JULIA B. HARRISON			2. DATE AND HOUR OF DEATH 3/14/72 10:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2562		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Gen. Hosp. 3001 S. Hanover St. Baltimore, Md. 21230			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 909 Bunche Road					
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-97	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard Harrison			14. MOTHER'S MAIDEN NAME Levina? Mason		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-30-6813A		17. INFORMANT Wilbur Harrison 909 Bunche Rd
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Edema 18 hrs. (B) DUE TO OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure sev. years. (C) Arteriosclerotic Heart Disease sev. years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sev. years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 1969 to Mar. 1972, that (I) (we) last saw the deceased alive on Mar 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Colvin C. Carter, M.D.				23B. DATE SIGNED 3/14/72	
23C. PHYSICIAN'S NAME (Type) Colvin C. Carter M.D.				23D. ADDRESS 3001 S. Hanover St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3-16-72		Coney Cat Creek	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR R. E. Bailey, M.D.		25C. FUNERAL DIRECTOR E. W. Wilson 1000 B. Hwy Ave	

4-20-77

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-5530		72 02655		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02655	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Ruth Raymond			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 3-12-72 4:25 A M.			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 501			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 412 Mott St.							
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-18	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Stoneware						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James White				14. MOTHER'S MAIDEN NAME Fannie Lewis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-30-9440		17. INFORMANT John White	
18. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) HEPATIC coma Severe portal cirrhosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2 none				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (1) (this hospital) attended the deceased from MAR 12 19 72 to MAR 12 19 72, and that (1) (we) last saw the deceased alive on MAR 12 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Seneduk A. Lerman M.D.				23B. DATE SIGNED 3/12/72		23C. PHYSICIAN'S NAME (Type) Seneduk A. Lerman	
23D. ADDRESS —				23E. ADDRESS —		23F. ADDRESS —	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-16-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md.				24E. LOCATION (City, town, or county) (State) —		24F. LOCATION (City, town, or county) (State) —	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972				25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR Chas. J. Wilson	
25D. ADDRESS —				25E. ADDRESS —		25F. ADDRESS —	

Chas. W. O. 1008-1010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02656

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN H. WILLIAMS				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1025 Harlem Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 13 1972 12:15 p.m.			
6. SEX male				7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov 26 - 1896				10. AGE (In years last birthday) 75		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Williams Sr			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				14B. KIND OF BUSINESS OR INDUSTRY ?			
15. MOTHER'S MAIDEN NAME Rachel				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS Mary Williams Lane			
19. CAUSE OF DEATH 492 X 1 Pulmonary emphysema DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 3-13-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-17-72			
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem				24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972				25B. NAME OF REGISTRAR John E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Edwin J. Brantly				ADDRESS			

12-10-12

12-10-12
Baltimore Md
Robert
to

My William
Robert
John Williams

Robert

Annual 8-10-12 Baltimore Md
Robert Williams

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-512		72 02657		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02657	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Thompson Joseph</i>				2. DATE AND HOUR OF DEATH <i>3/9/72 5:30 p</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>301</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>5 Church Home & Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1627 E. Pratt St.</i>			
5. SEX <i>M</i>	6. RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/26/27</i>	9. AGE (in years last birthday) <i>44</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph Thompson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Hudson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary Thompson</i>		ADDRESS	
18. <i>263.91 + 303.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute MI</i> (B) <i>Pneumonia, Chronic & acute alcohol.</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Wernich encephalopathy.</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>few hrs.</i> <i>undetermined</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3-9-</i> <i>1972</i> to <i>3-9-</i> <i>1972</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Edna M. ... MD</i>				23B. DATE SIGNED <i>3/9/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>GERHMA P. INDOLOMA</i>				23D. ADDRESS <i>Church Home & Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>3-14-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Mary's Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Alameda County MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Edna M. ...</i>		ADDRESS <i>1000 ...</i>	

man

very

Ar

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Oliver J. Harker, Jr. Sr.

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Balto. City Hospital

3. DATE

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Baltimore

6. SEX

male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Jan. 17, 1906

10. AGE (In years last birthday)

66

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

7622 Cedar Road

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Philmore Harker

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machinist

14B. KIND OF BUSINESS OR INDUSTRY

Beth. Steel Co.

15. MOTHER'S MAIDEN NAME

Ida Mae Carback

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

213-09-4398

18. INFORMANT

Wife:

7622 Cedar Road

Mrs. Helen M. Harker Dundalk, Md. 21222

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/10/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-14-72

24C. NAME of CEMETERY or CREMATORY

Holly Hill Mem. Gardens

24D. LOCATION (City, town, or county) (State)

White Marsh, Maryland

25A. DATE REC'D-BY HEALTH DEPT

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 16 1972

John J. Duda

John J. Duda 7922 Wise Ave. Dundalk, Md.

CERTIFICATE AMENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-235 72 02659		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02659	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HERBERT BOSTON		2. DATE AND HOUR OF DEATH 14 MAR 1972 10 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1401		C. CITY OR TOWN DALLAMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GEN HOSP 48		E. STREET AND NUMBER 259-N. Robert St		5. SEX M 6. RACE B 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired		8. DATE OF BIRTH 4-9-09 9. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) Chester, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Boston	
14. MOTHER'S MAIDEN NAME Hannah Boston		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes Apr 5-1943-Oct 9, 1945		16. SOCIAL SECURITY NO. 25-07-2506	
17. INFORMANT Vivian Lowery		ADDRESS 4915-St. Georges Ave.		18. 4-27-014-1972-8 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE D.I.C.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HR.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF: SEPSIS - GRAM NEG CIRCULOSIS & Hepatic Carcinoma		YEARS	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: CHF		72 HRS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) CHRONIC RENAL FAILURE		YEARS	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		YEARS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 13 MAR 1972 to 14 MAR 1972		that (I) (we) last saw the deceased alive on 14 MAR 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Sherman Kahn MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/14/72	
23C. PHYSICIAN'S NAME (Type) SHERMAN KAHN MD		23D. ADDRESS MD GEN HOSP		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 3-18-72		24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel, MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert E. Taylor	
25D. ADDRESS 2000 E. Pratt St.		25E. ADDRESS 2000 E. Pratt St.		25F. ADDRESS 2000 E. Pratt St.	

254-21 Robert St

4-0-02 402

Chapel Road,
Lancashire

important over map

Retained

Handy Book

for information to be used in map of 1902

Survey of the County of Lancashire
Lancashire

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02660	
CERTIFICATE OF DEATH				REG. NO. 72 02660	
BIRTH NO. <u>W-252 72 02660</u>					
1. NAME OF DECEASED (Type or Print) <u>Washington Grover</u>		2. DATE AND HOUR OF DEATH <u>3/10/72 19-05 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>43</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u> B. COUNTY <u>21215</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2639 Quantico Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/06/1916</u>	9. AGE (In years last birthday) <u>56</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>INGRAM Washington</u>		14. MOTHER'S MAIDEN NAME <u>Louanna Small</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-01-8828</u>		17. INFORMANT <u>Mazie Washington</u>	
				ADDRESS <u>-2639 Quantico Ave</u>	
18. <u>163-1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Resp obstruction</u> (B) <u>Bronchogenic Carcinoma in Brain</u> DUE TO, OR AS A CONSEQUENCE OF: <u>metastases</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/4/1972</u> to <u>3/10/1972</u> that (I) (we) last saw the deceased alive on <u>3/9/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>P. SUBBARAO M.D.</u>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-14-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION <u>Ba. Hinore, Md.</u>		24E. CITY, TOWN, OR COUNTY (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Hope Town Dye & F. H. 1701-Lawrence St.</u>	

10-10-1944
10-10-1944

10-10-1944
10-10-1944
10-10-1944

10-10-1944
10-10-1944

10-10-1944
10-10-1944

10-10-1944
10-10-1944

10-10-1944
10-10-1944

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02661

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ERNEST L. KNOX		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Md. Gen. Hosp. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year 3 12 1972 11:05a M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 3841	
9. DATE OF BIRTH July 2, 1952		10. AGE (In years lost birthday) 19 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		14B. KIND OF BUSINESS OR INDUSTRY STUDENT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Marjorie Lee		18. INFORMANT Mrs. Marjorie Nixon	
19. 304.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-13-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-72	
24C. NAME OF CEMETERY or CREMATORY Lively Hope Cemetery		24D. LOCATION (City, town, or county) (State) Calla, Va.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F. H.		ADDRESS 1701 Laurens St.	

4-5-1972 - Completion of cause of death on a pending medical examiner death certificate.

Russell S. Fisher, M.D.

HRS

(M 2-3 7)

July 1, 1972

Exhibit 1

Exhibit 2

on

MAILED
JUL 1 1972

W. H. H.

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

July 1, 1972

N-253

72 02662 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02662

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATHERINE NEUGENT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 12 1972 11:43p M.	
6. SEX female		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2833	
9. DATE OF BIRTH May 3, 1933		10. AGE (In years lost birthday) 38 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Anderson, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		14B. KIND OF BUSINESS OR INDUSTRY Dept. Social Services	
15. MOTHER'S MAIDEN NAME Carrie Ellis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 203-26-6532		18. INFORMANT ADDRESS Katherine P. Neugent 5000 Corley Rd.	
19. 400.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Malignant hypertension with external hemorrhage from anastomosis site for dialysis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-13-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-72	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Morton S. Dyett		ADDRESS F. H. 1701 Laurens St.	

4-11-1972 - Completion of cause of death on a pending medical examiner death certificate
Russell S. Fisher, M.D.

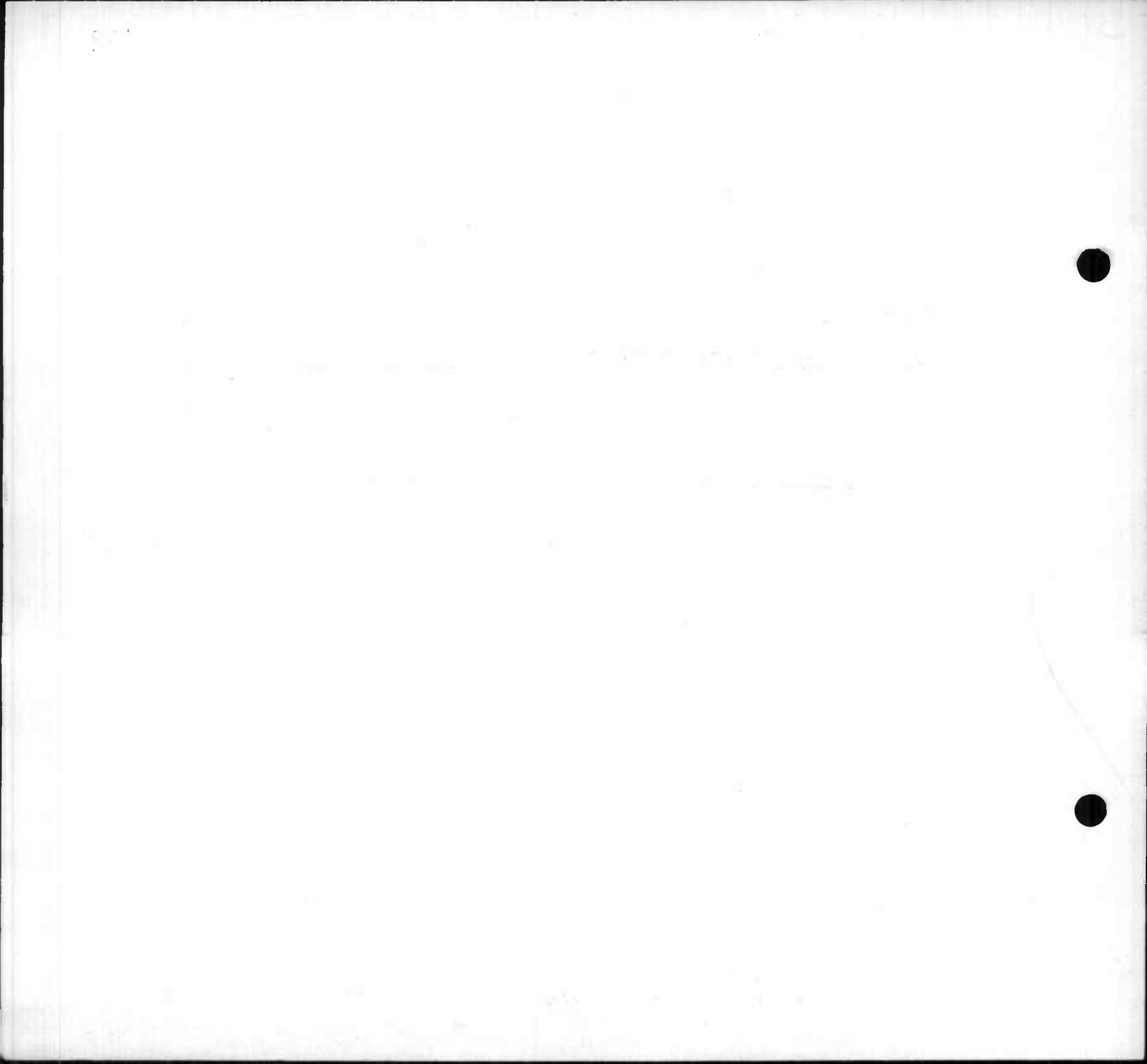
HRS

4/12/72 - Analysis for Kidney - med exam - gc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

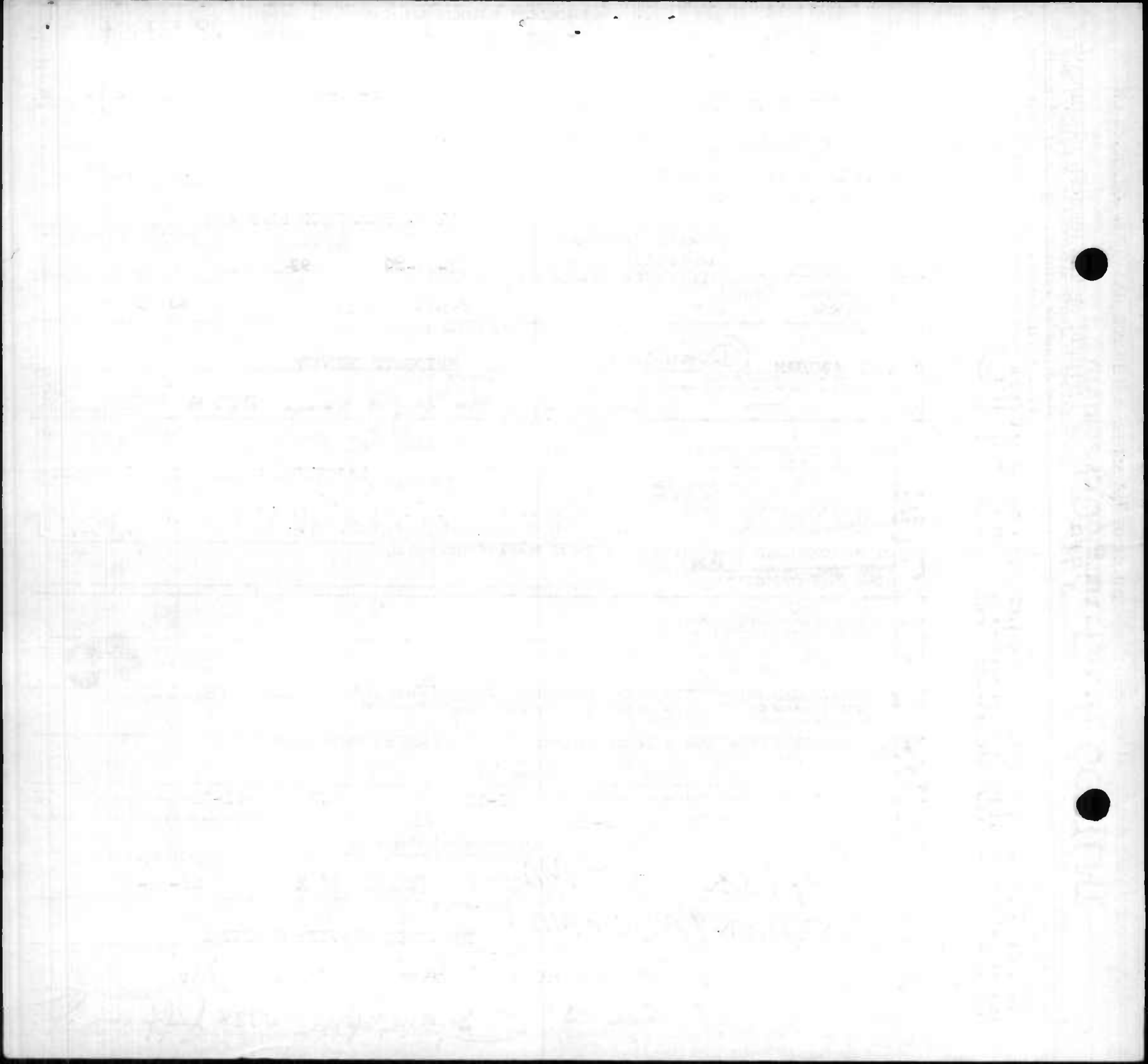
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02663	
BIRTH NO. 72 02663				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>James W. Staples</u>			2. DATE AND HOUR OF DEATH <u>3/13/72</u> <u>1 5 45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balt. city</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1610^W Balt. St.</u> <u>21023</u>		
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/1/1900</u>	9. AGE (in years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Taylor G. Staples</u> <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown Bessie</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>217-09-3372</u>	17. INFORMANT <u>Marie H. Freshback</u> <u>LPN</u>		
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>1 Month</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/29/72</u> 19 to <u>3/13/72</u> 19 that (I) (we) last saw the deceased alive on <u>3/13/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Yunyong Yunyongying</u>			23B. DATE SIGNED <u>3/13/72</u>		23C. PHYSICIAN'S NAME (Type) <u>YUNYONG YUNYONGYING</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3/13/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>			25B. NAME OF REGISTRAR <u>J. E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Marie H. Freshback</u>
25D. ADDRESS <u>BON SECOURS HOSPITAL</u>			25E. ADDRESS <u>2101 E. Pratt Ave</u> <u>21023</u>		



FUNERAL DIRECTOR: IMPORTANT

APPROVAL BY DR. LIPKOVIC OF THE MEDICAL EXAMINER'S
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death was a fracture of any kind; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02664				-BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02664	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANNIE ROBINETTE				03-10-72 9:13 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21231				A. STATE MARYLAND B. COUNTY 603			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 222N. PATTERSON PARK AVE							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-04-00	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BARNEY DUNIGAN (DUNNIGAN)			14. MOTHER'S MAIDEN NAME BRIDGETT DENVER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-07-4774		17. INFORMANT Mrs. Mary A. Keiser - 222 N. Patterson St.		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CERTIFICATION APPROVED BY ANTHONY J. [Signature] DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) Marking the UNDERLYING CONDITION IN I.			CAUSE OF DEATH CARDIAC & RESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 03-12-1972 to 03-12-1972 that (we) last saw the deceased alive on 03-12-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stephen Page MD						23B. DATE SIGNED 03-12-72	
23C. PHYSICIAN'S NAME (Type) STEPHEN PAGE, MD						23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-14-72		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS		24D. LOCATION BALTO., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 02665</u>	
BIRTH NO. <u>72 02665</u>		<u>9-11-19-13 67</u>					
1. NAME OF DECEASED (Type or Print) <u>KATHERINE E. STALLINGS</u>				2. DATE AND HOUR OF DEATH <u>3/15/72</u> <u>1:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>CHURCH HOME & HOSTP.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>603</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME & HOSTP.</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>107 N. BRADFORD ST. #21224</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/03</u>	9. AGE (in years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED HOUSE WORK</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MILKE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH DIETERMAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>911-19-1367</u>		17. INFORMANT <u>PT'S, HOSP. CHART</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>199.014011.9</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				CAUSE OF DEATH <u>POSSIBLE GENET. MALIGNANCY</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ENDOCRINE DISORDERS UNDETERM.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ANEMIA</u> <u>POSSIBLE TUBERCULOSIS UNDETERM.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month () 1 Day () 1 Year () 1 Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/13</u> 19 <u>72</u> to <u>3/15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dieterich V. Feldmann M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DIETRICH V. FELDMANN M.D.</u>				23D. ADDRESS <u>CHURCH HOME & HOSTP.</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-18-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. CARMEL CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>5712 O'DONNELL ST, BALTO, 21224, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Jester</u> ADDRESS <u>901 S. CONKLING ST. BALTO., 21224, MD.</u>			

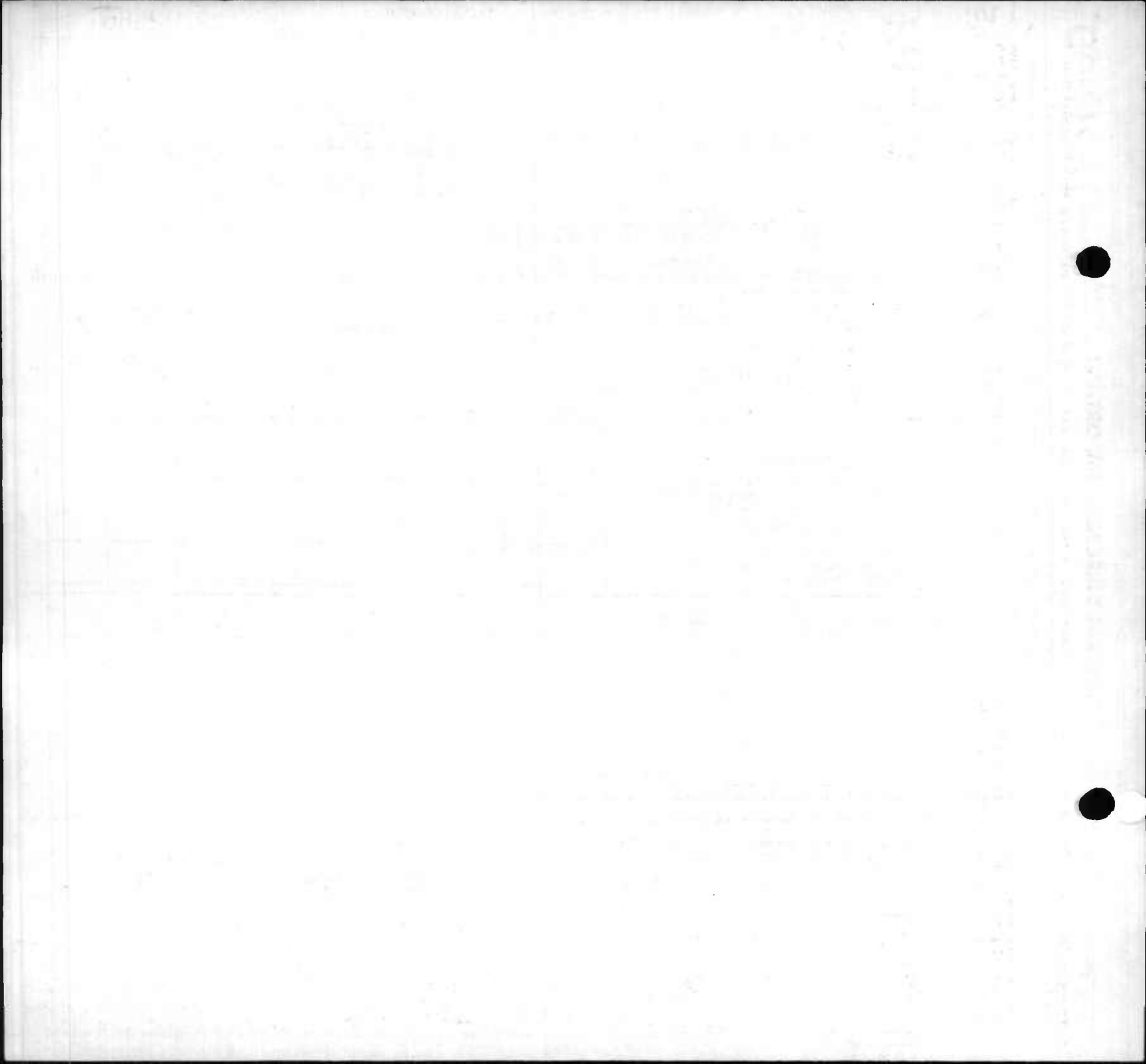
BALTIMORE

100

FUNERAL DIRECTOR: IMPORTANT

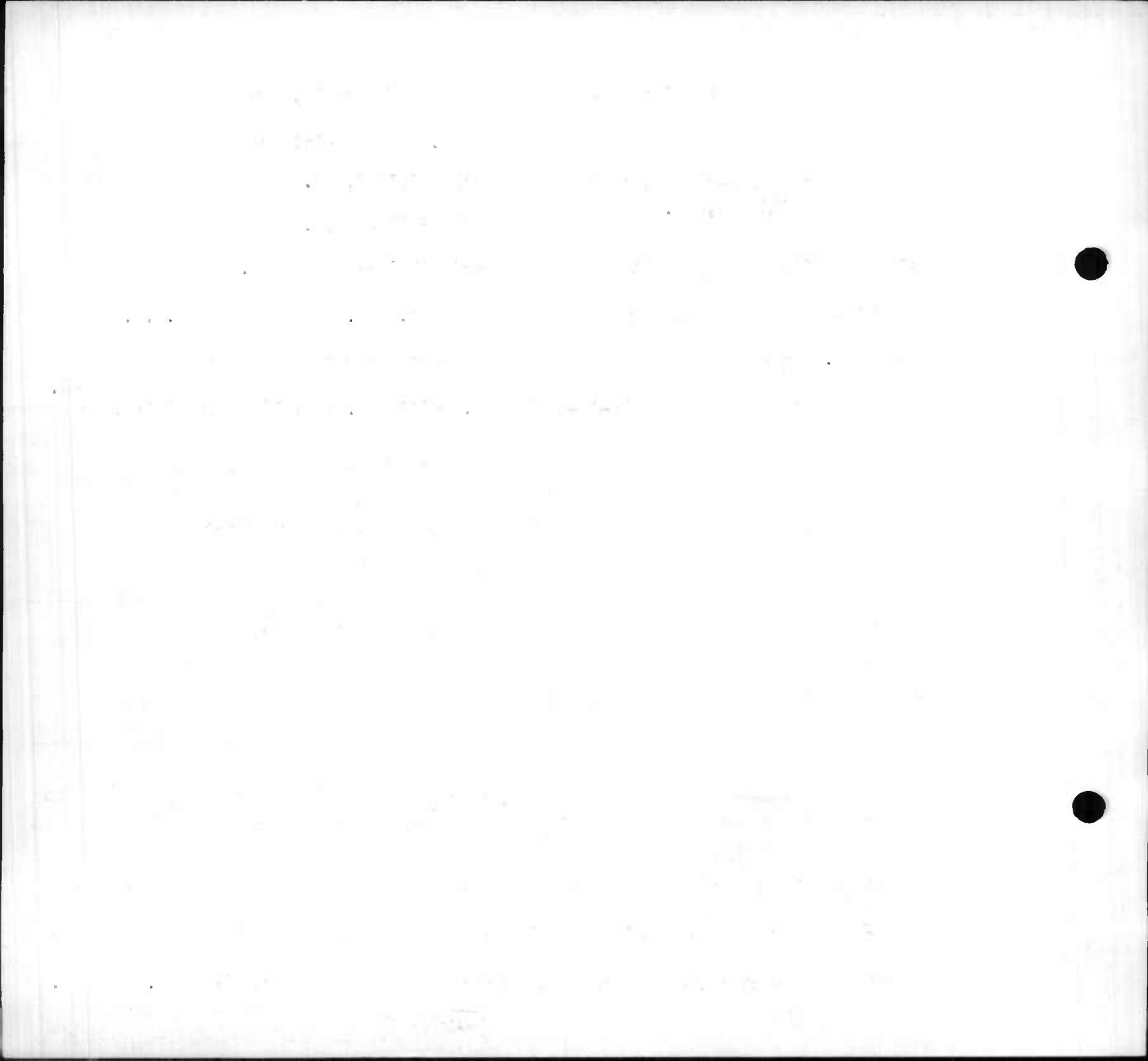
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02666</u>	
BIRTH NO. <u>72 02666</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ZITO, VINCENT</u>		2. DATE AND HOUR OF DEATH <u>3.10.72</u> <u>9.36 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u> <u>BALTIMORE, Md.</u>		A. STATE <u>BALTIMORE</u> B. COUNTY <u>Co. / MD</u>			
		C. CITY OR TOWN <u>PIKEVILLE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>1220 Reisterstown</u> <u>5300</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10.17.89</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CAKING BAKERY</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>VINCENT ZITO</u>			
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>YES</u> <u>W.W.I</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. VINCENT ZITO, 1220</u>			
18. <u>412.4-204.9</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic shock</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ASCND</u> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Probable lymphatic leukemia</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3.9.72</u> to <u>3.10.19.72</u> that (I) (we) lost saw the deceased alive on <u>3.10.19.72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marco Varini, MD</u>				23B. DATE SIGNED <u>3.10.72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARCO VARINI</u>				23D. ADDRESS <u>SINAI HOSP - BALTIMORE / MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Funeral Home 13 Eastern Ridge Center</u>		24B. DATE <u>MAR 16 1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Pikesville Park</u>	
24D. LOCATION (City, town, or county) <u>Pikesville, Md.</u>		24E. (State) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frank H. Howell, Pikesville, Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

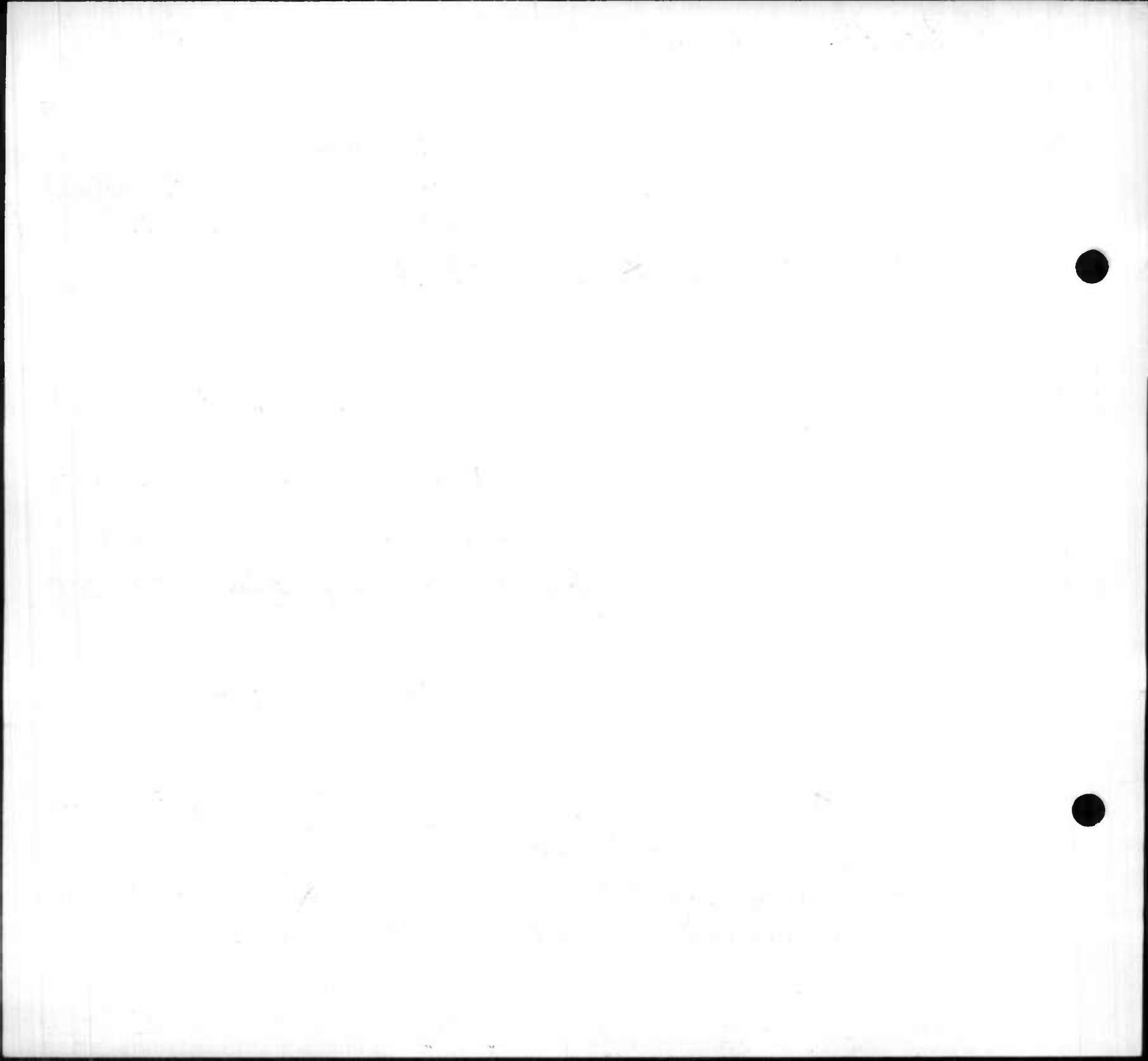
72 02667		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02667	
1. NAME OF DECEASED (Type or Print) Elizabeth Briscoe Lee			2. DATE AND HOUR OF DEATH March 10, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore 5300		
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 17, 1883 9. AGE (In years? last birthday) 83 yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Kent Co., Md.		
13. FATHER'S NAME Samuel R. Brown			14. MOTHER'S MAIDEN NAME Augusta Thompson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-48-0534		
17. INFORMANT Mr. William B. Lee, 1168 Outer Drive, Hagerstown			ADDRESS Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I 4 250.9 Massive myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary artery disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 18 19 71 to January 7 19 72 that (I) (we) last saw the deceased alive on January 7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE Samuel P. Skala, M.D.			23B. DATE SIGNED 3-13-72		
23C. PHYSICIAN'S NAME (Type) SAMUEL P. SKALA, M.D.			23D. ADDRESS 2 Howard Avenue Pikesville, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 13, 1972		24C. NAME OF CEMETERY or CREMATORY Chester Cemetery	
24D. LOCATION (City, town, or county) (State) Chestertown, Kent Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR Frank A. Newell, Pikesville 8, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-642		72 02668		BALTIMORE CITY HEALTH DEPARTMENT		72 02668	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) Lottie Burleson				2. DATE AND HOUR OF DEATH 3/13/72 9 15 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY 1803			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 820 W. Lombard St.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/26	9. AGE (In years last birthday) 45	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?			
17. INFORMANT Ann Williamson				ADDRESS 46 Perkins St. 21201			
18. 410.9 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Edema		3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Acute Renal Failure DUE TO, OR AS A CONSEQUENCE OF:		2 days	
				(C) Acute Myocardial Infarction		4 to 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 3/11 19 72 to 3/13 19 72 that (we) last saw the deceased alive on 3/13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. E. Mahaffey MD				23B. DATE SIGNED 3/14/72			
23C. PHYSICIAN'S NAME (Type) J. E. MAHAFFEY M.D.				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/72		24C. NAME OF CEMETERY OR CREMATORY Green Haven Cem.		24D. LOCATION (City, town, or county) (State) Green Haven Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Z...		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc.		ADDRESS Hallist St. 21223	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-624		72 02669		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02669	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GERTRUDE E. BRAECKLEIN				2. DATE AND HOUR OF DEATH March 14, 1972 12:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1154 Cleveland Street Baltimore, Maryland 21230				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 2102			
5. SEX Female				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-14-1884		9. AGE (In years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William David Lippy		14. MOTHER'S MAIDEN NAME Sarah C. Feazer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-07-4928D		17. INFORMANT Miss Helen P. Braecklein, 1154 Cleveland St.		ADDRESS 21230			
18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) Cerebral Arteriosclerosis (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 12 years	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-15 1960 to 3-14 1972, that (I) (we) last saw the deceased alive on 3-13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John P. Urlock, Jr.				23B. DATE SIGNED 3/14/72		23C. PHYSICIAN'S NAME (Type) John P. Urlock, Jr.	
23D. ADDRESS 1227 Washington Blvd., Baltimore, Md. 21230				23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-16-1972		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 15 1972		25B. NAME OF REGISTRAR 2000		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

100

100

100

100

100

100

100

100

100

100

100

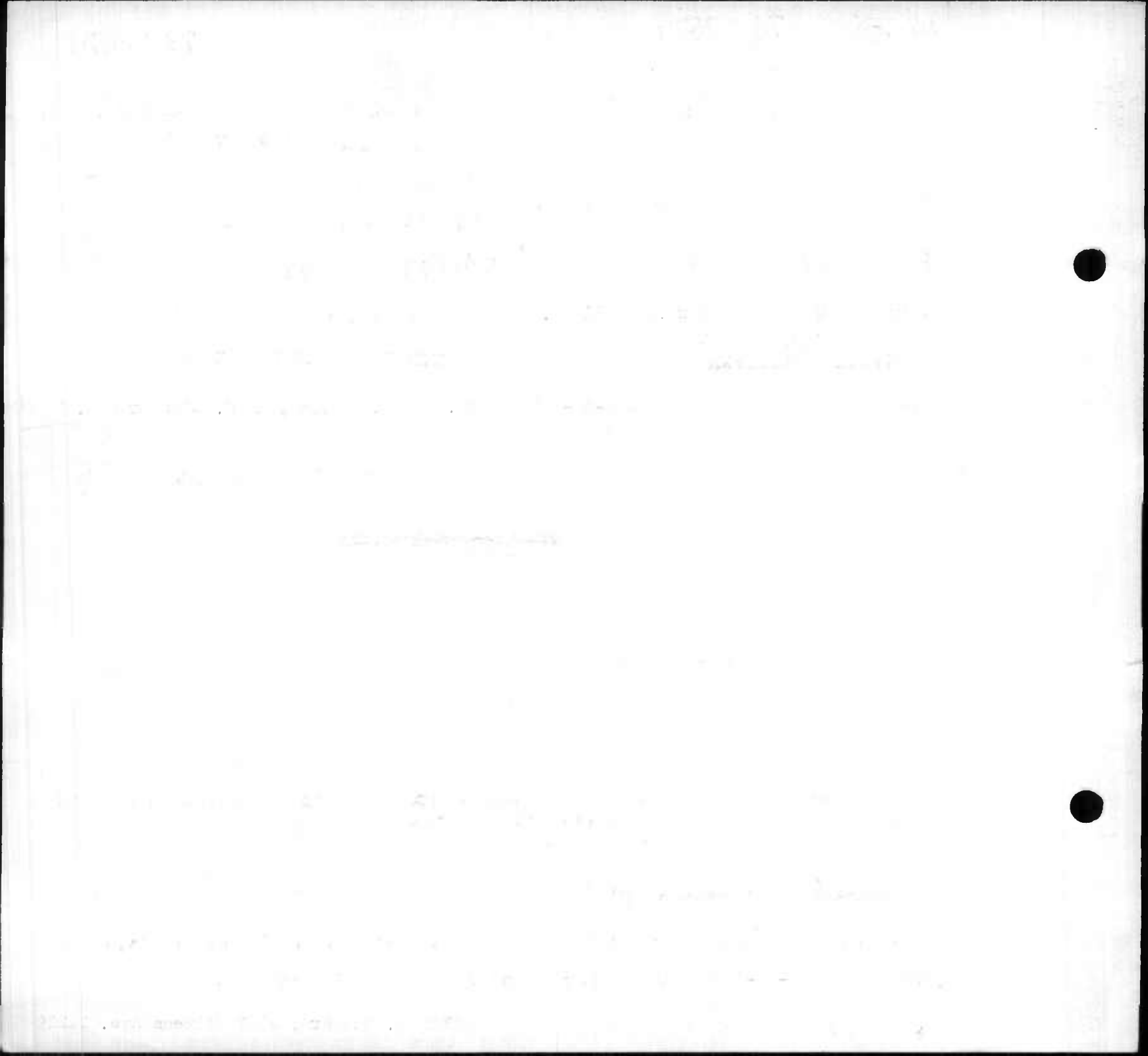
100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

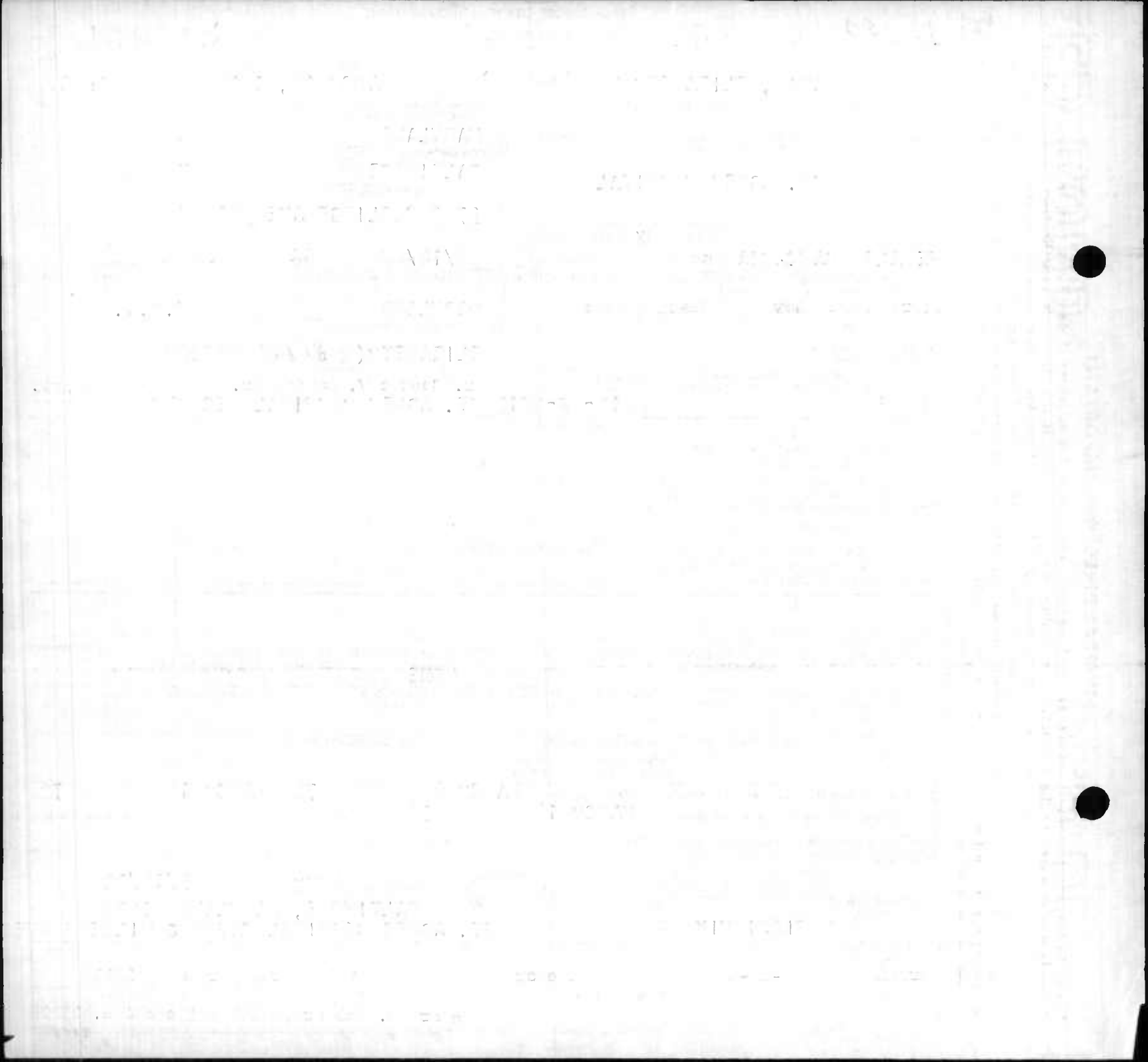
BIRTH NO. M-526		72 02670		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02670	
1. NAME OF DECEASED ANNIE MANSER (Type or Print) <i>Annie Manser</i>				2. DATE AND HOUR OF DEATH <i>3/13/72 12:05 P.M.</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN <i>Linthicum</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>16 Eleanor Avenue</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/12/93</i>	9. AGE (In years last birthday) <i>78</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Corkran Hill Co.</i>					
13. FATHER'S NAME <i>HENRY MANSER</i> <i>XXXXXXXXXXXXXXXXXXXX</i>				14. MOTHER'S MAIDEN NAME <i>WILHEMIA MANS WICKE</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-19-9579</i>		17. INFORMANT ADDRESS <i>Mrs. Oliver Bullen, 16 S. Eleanor Ave. 21090</i>			
18. <i>441.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Cherry Sm of Thoracic aorta</i> DUE TO, OR AS A CONSEQUENCE OF: (B) Cherry Sm of Thoracic aorta DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>? - 1 year?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>March 12</i> 19 <i>72</i> to <i>March 13</i> 19 <i>72</i> that (1) (we) lost saw the deceased alive on <i>March 13</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Richard A. Tomasulo M.D.</i>				23B. DATE SIGNED <i>3/13/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Richard A. Tomasulo M.D.</i>			
23D. ADDRESS <i>Univ. of Maryland Hosp., Balt., Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-17-1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 16 1972</i>		25B. NAME OF REGISTRAR <i>2000</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		25D. ADDRESS <i>4107 Wilkens Ave. 21229</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

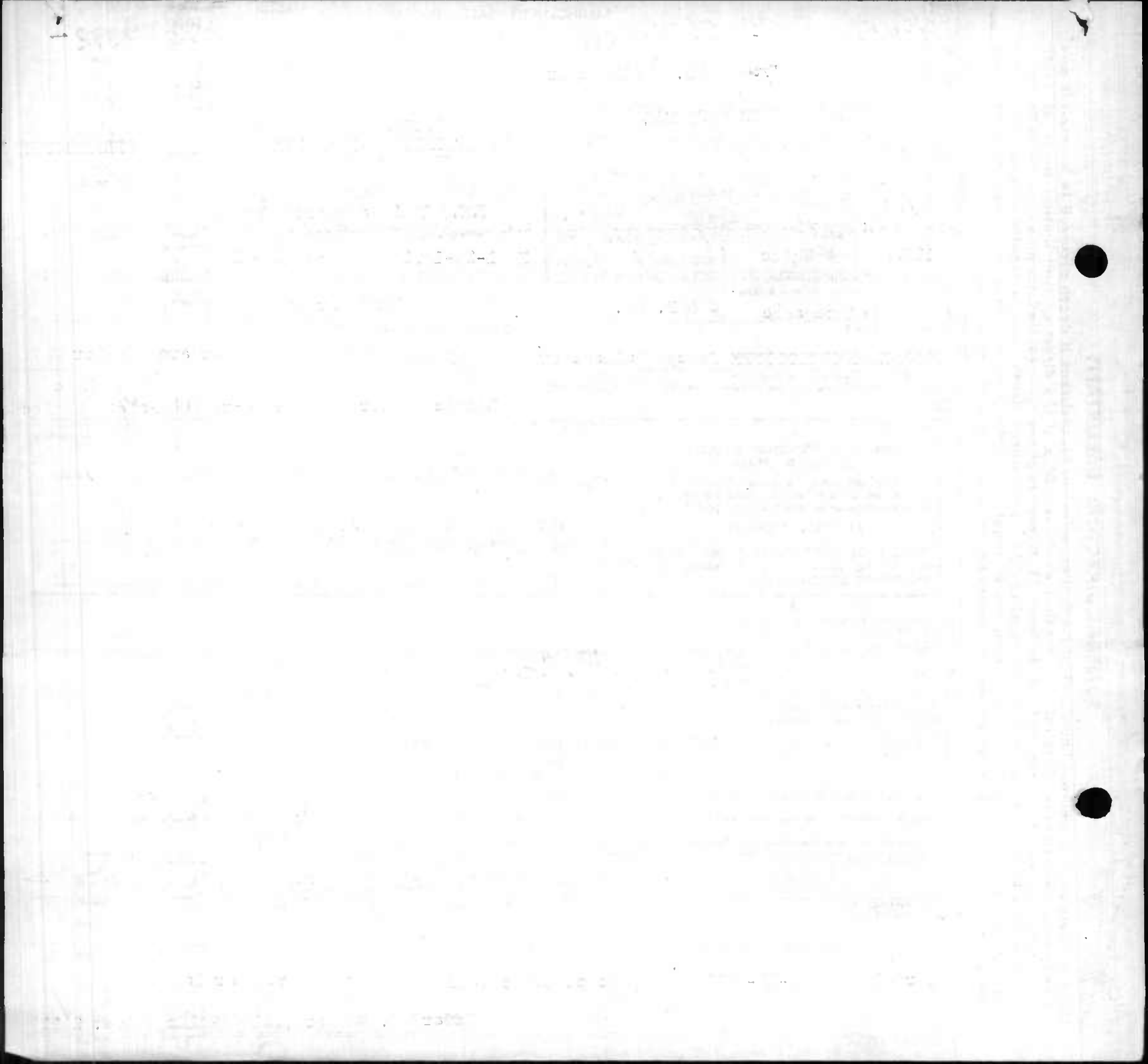
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02671</u>	
D-120 ³⁰⁰ 72 02671		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) DAVIS, ELIZABETH M (DOODY)		2. DATE AND HOUR OF DEATH MARCH 14, 1972 5:45A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2551 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3703 COOLIDGE AVE 21229			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/14/05 66	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Assembler		10B. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN DOODY			
14. MOTHER'S MAIDEN NAME ELIZABETH (Shannon) DOODY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			
16. SOCIAL SECURITY NO. 212-05-2517		17. INFORMANT Mr. George F. Davis, Jr. 3703 Coolidge Ave 21229			
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Post-resus Status following</i> DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial Infarction</i> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NONE	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 4 19 72 to MARCH 14 19 72 that (I) (we) last saw the deceased alive on MARCH 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Yousuf Siddiqui</i>		23B. DATE SIGNED 03/14/72			
23C. PHYSICIAN'S NAME (Type) M SIDDUQUIM MD		23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-1972		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224					
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

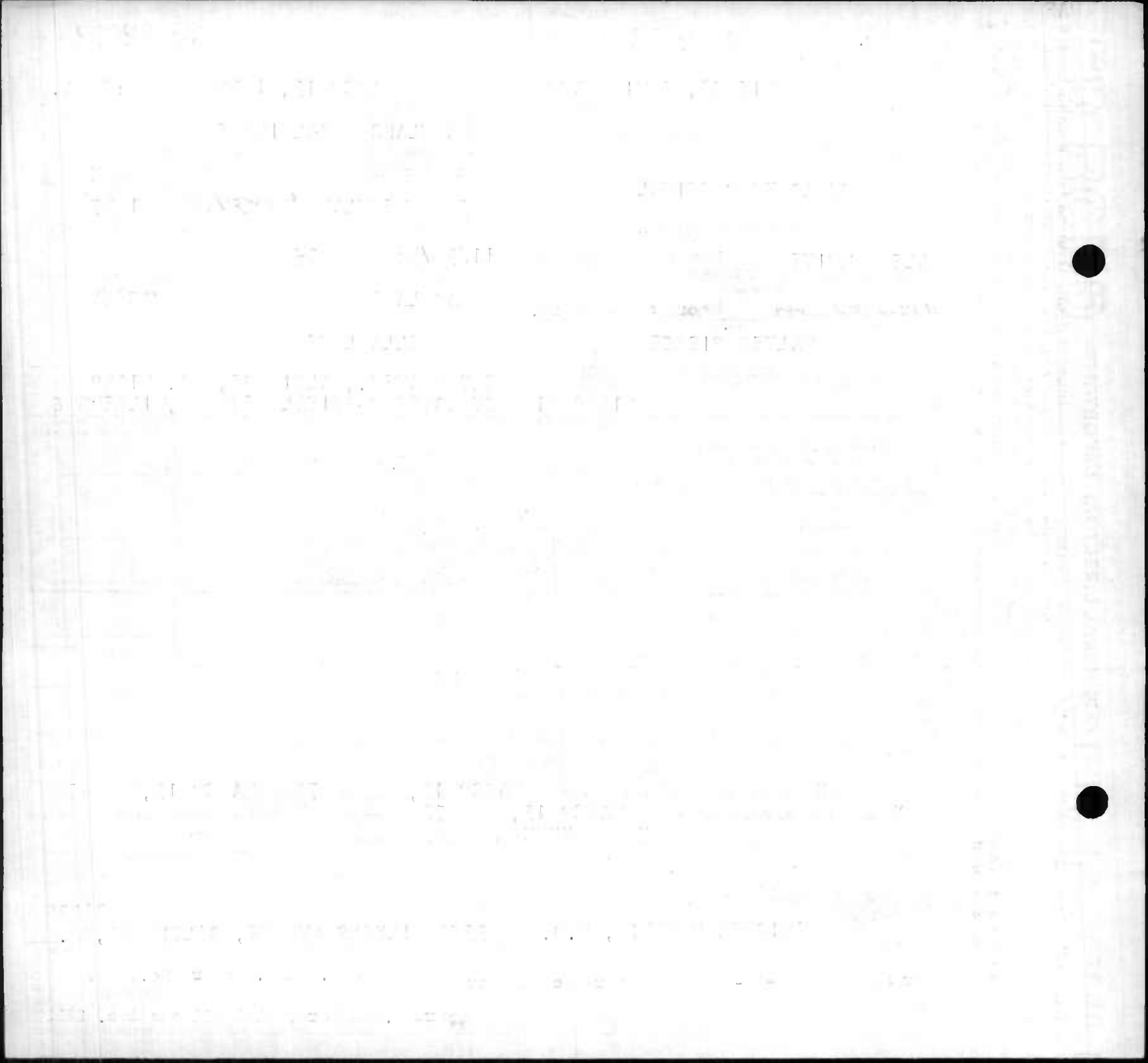
H-456 72-2672				BIRTH NO.		REG. NO. 72 02672	
1. NAME OF DECEASED (Type or Print) <u>Frank Hallameyer</u>				2. DATE AND HOUR OF DEATH <u>3/14/72</u> <u>16:45</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital - W. Balto + Pulaski Sts Balto 21223 Md.</u>				A. STATE <u>MARYLAND</u>		CITY OR TOWN <u>BALTO 21228 Md.</u>	
				D. INSIDE CITY LIMITS? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input type="checkbox"/>			
5. SEX <u>MALE</u>				6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>1-24-1892</u>				9. AGE (In years last birthday) <u>80</u>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Maintenance</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>C & P. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Hallameyer</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Kohler</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-05-0536A</u>				17. INFORMANT <u>Little Sisters of the Poor, 601 Maiden Choice Lane</u>			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <u>Consentive heart failure</u> <u>days</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) <u>Atherosclerotic Heart Disease</u> <u>years</u>			
ANTECEDENT CAUSES				(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>3-7-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Adenocarcinoma of Colon</u>		20A. AUTOPSY (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? _____		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED _____		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (1) (this hospital) attended the deceased from <u>2-29-1972</u> to <u>3-14-1972</u>		that (1) (we) last saw the deceased alive on <u>2-14-1972</u> and that (2) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chiu T. Wang MD</u>				23B. DATE SIGNED <u>3-14-72</u>			
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS _____			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-17-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 16 1972</u>		25B. NAME OF REGISTRAR <u>John J. ...</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>MAF 1</p> <p>P-620</p> <p>72 02673</p>		<p>CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p> <p>REG. NO. 72 02673</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p> <p>MARCH 13, 1972 8:50 A. M.</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p>PIERCE, EDWIN MAYHEW</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTIMORE</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>40 ST AGNES HOSPITAL</p>		<p>C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>E. STREET AND NUMBER 5000 WESTLAND BOULEVARD 21227</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Retired Machinist</p>		<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY American Can Corp.</p>		<p>12. CITIZEN OF WHAT COUNTRY? U S A</p>	
<p>13. FATHER'S NAME WALTER PIERCE</p>		<p>14. MOTHER'S MAIDEN NAME ELLA LOPER</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>No</p>		<p>16. SOCIAL SECURITY NO. 218260018</p>	
<p>17. INFORMANT ADDRESS CATON AVES., BALTIMORE, MD. 21229</p>		<p>ST AGNES HOSPITAL RECORDS, WILKENS &</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>344.1 I</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Left low lake pneumonia</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: Relapsing fever</p>	
<p>(C) DUE TO, OR AS A CONSEQUENCE OF: Hemiplegia</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from MARCH 12, 1972 to MARCH 13, 1972 that (I) (we) last saw the deceased alive on MARCH 13, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p>MIGUEL HEREDIA, M.D.</p>		<p>23B. DATE SIGNED 3/13/72</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS 3350 WILKENS AVENUE, BALTIMORE, MD. 21229</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3-16-1972</p>	
<p>24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972</p>		<p>25B. NAME OF REGISTRAR Howard H. Hubbard</p>	
<p>25C. FUNERAL DIRECTOR ADDRESS</p>		<p>4107 Wilkens Ave. 21229</p>	



CSA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02674	
H-535 72 02674				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HINDMAN, ELVIRA HELENE			MARCH 11, 1972 3:20 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
40 ST AGNES HOSPITAL			MARYLAND		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			4301 PARKTON ST - 21229		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
FEMALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12 31 03	68	11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
SUPERVISOR			BLIND MD WORKSHOP FOR		NEW JERSEY
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
ERNEST SCHLEUNING			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			218-12-0166		ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Cardiogenic shock		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Myocardial Infarction		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Arteriosclerosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)
2					YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
1 Month 1 Day 1 Year 1 Hour			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from 03 01 1972 to 03 11 1972 that (X) (we) last saw the deceased alive on 03 11 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
S. Lee			March 11, 1972		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
JOUNG SOON LEE, M.D.			ST AGNES HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial		3-14-1972	Mt. Olivet Cemetery		Frederick Rd. Balto. Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 16 1972		John E. Fisher, M.D.		Hubbard Funeral Home Inc. 4107 Wilkens Ave.	

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

12-12-72

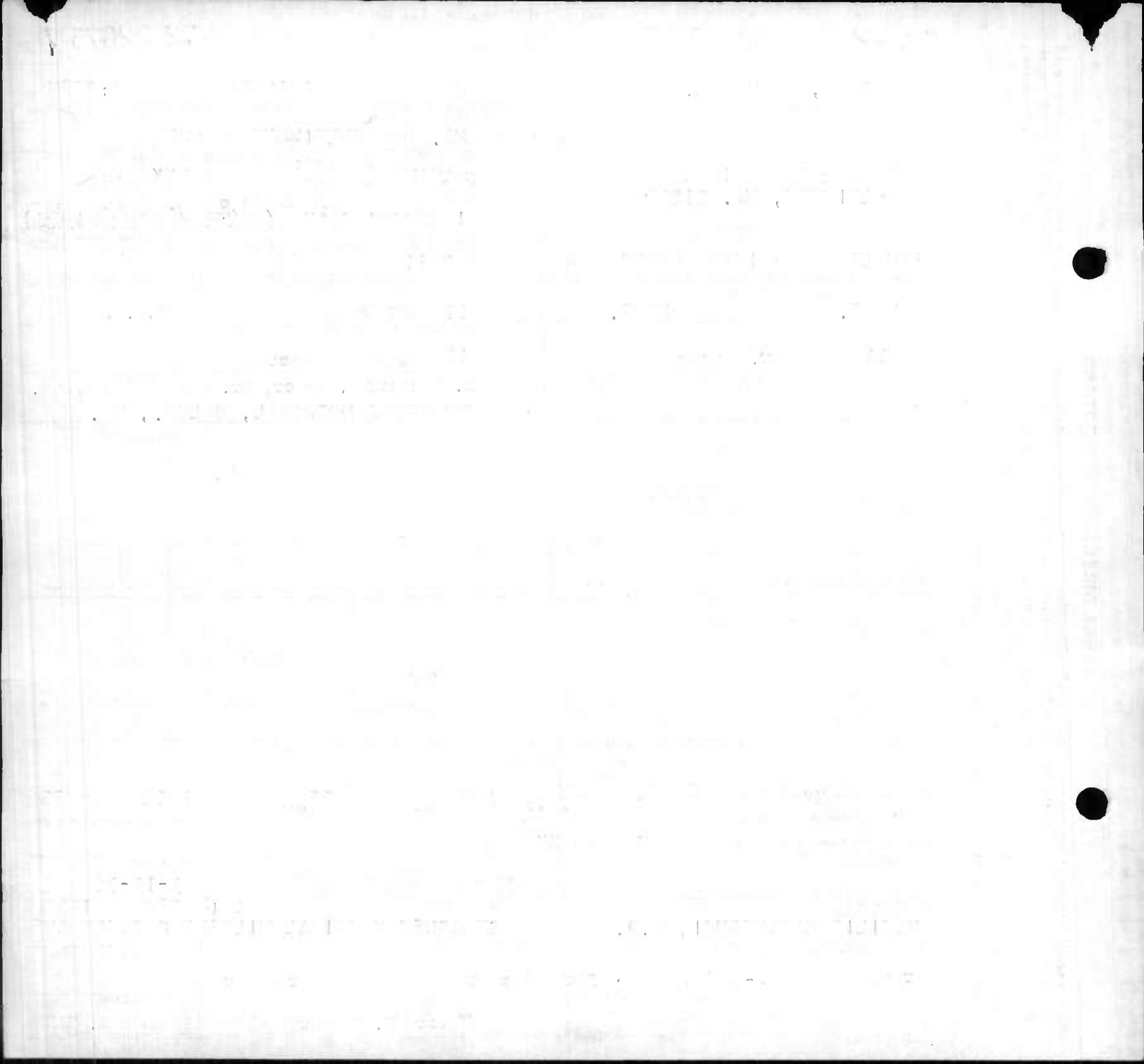
12-12-72

12-12-72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

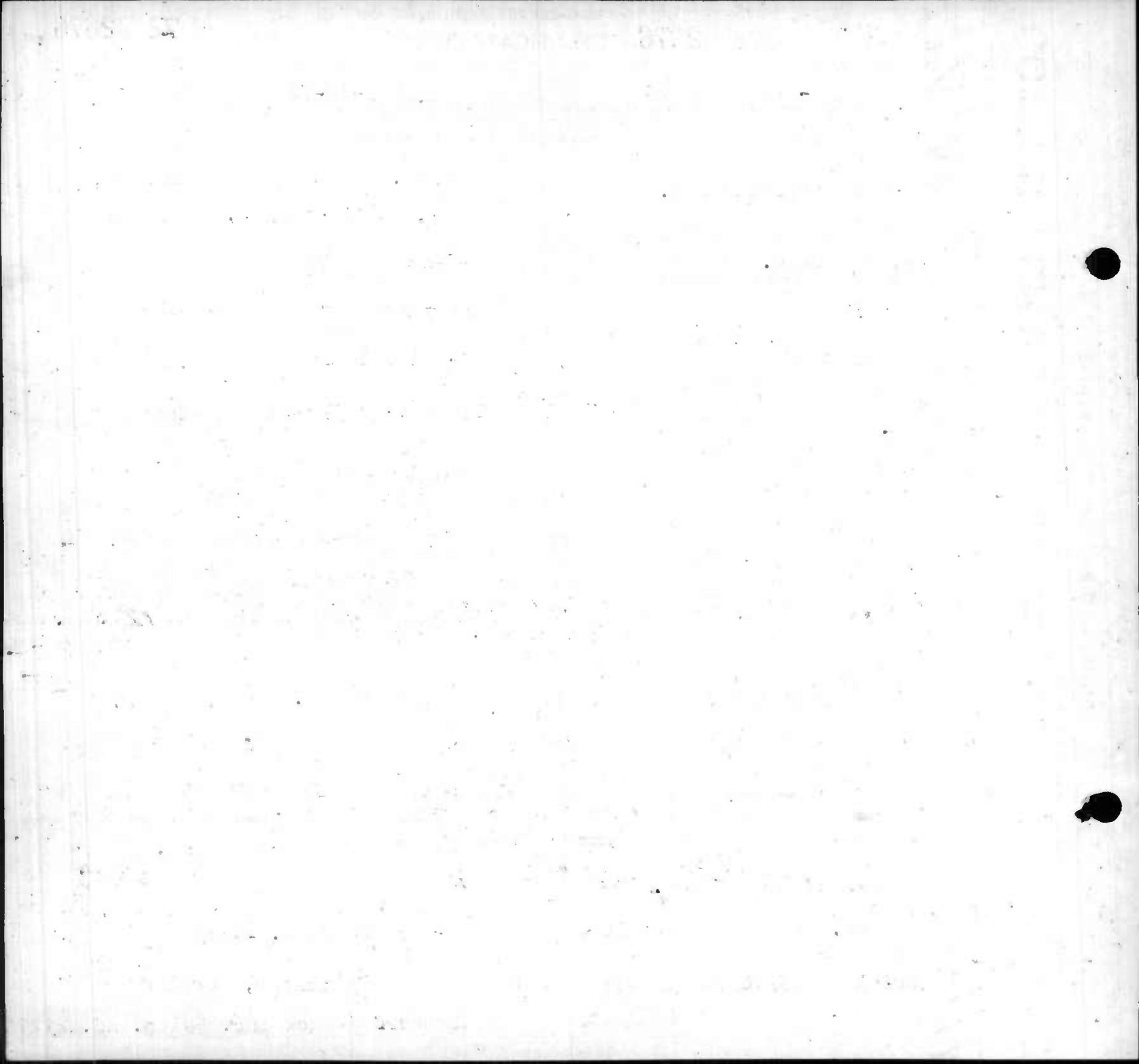
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02675	
BIRTH NO. B-160		72 02675		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ROPER, NAOMI E.			2. DATE AND HOUR OF DEATH 3 12 72 3:30PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL BALTIMORE, MD. 21229			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE Howard 6300 C. CITY OR TOWN Ellicott D. INSIDE CITY LIMITS? BALTIMORE City YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4556 College Ave. Ellicott City 16300 FUSTING AVE HOUSE XXXXXX RINE S		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 2 11	9. AGE (In years last birthday) 60	10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF.		10B. KIND OF BUSINESS OR INDUSTRY HSWF.		11. BIRTHPLACE (State or foreign country) XX Maryland	
13. FATHER'S NAME XX John T. Gibson			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. Chester E. Roper, Jr. 4556 College Ave. 21043			ADDRESS ST AGNES HOSPITAL, BALTO., MD.		
18. 25-0-71 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Myocardial infarct 6V DUE TO, OR AS A CONSEQUENCE OF: (B) Old Cerebral infarct DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes Mellitus, Puerperal Thrombosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2 9 1972 to 3 12 1972 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 12 1972 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Manay Louie</i>				23B. DATE SIGNED 03-13-72	
23C. PHYSICIAN'S NAME (Type) VASILIO KAKANTOUSI, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-1972		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME of REGISTRAR Howard H. Hubbard, 4107 Wilkens Ave. 21229			
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02676	
5-520 72 02676		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Anna E Schenk		2. DATE AND HOUR OF DEATH 3-12-72 7 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2912 Westfield Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2747 C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2912 Westfield Ave.	
5. SEX Female	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-92 9. AGE (In years last birthday) 79 If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Bahr		14. MOTHER'S MAIDEN NAME Agnes Feldman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-4259	
17. INFORMANT Mr Henry M Schenk		ADDRESS Same	
18. 412.4 14-017.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardio - Cerebro VASCULAR DISEASE		11 years	
(B) Chronic Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF:		3 years	
(C) LIVER TUBERCULOSIS		10 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MALABSORPTION SYNDROME due to MULTIPLE DIVERTICULA (ESOPHAGUS, DUODEN, COLON) MULTIPLE HERNIAS (ABDOMEN, DIAPHRAGM)		12 years	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (did not) attended the deceased from FEB 23 1954 to 3/12 1972 , that (I) did not first saw the deceased alive on MARCH 10 1972 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (did not) (did not) view the body after death.			
23A. SIGNATURE Dr. H. Hirschfeld DEGREE			23B. DATE SIGNED 3/13/72
23C. PHYSICIAN'S NAME (Type) Dr. John H Hirschfeld DEGREE		23D. ADDRESS 6919 Harford Rd. 21234	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/18/72	24C. NAME OF CEMETERY or CREMATORY Sacred Heart	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Balto. Md. 21214	



M-260

72 02677

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02677

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN E. MEAGHER, SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 6513 Harford Rd. Apt. 1A		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 13 1972 10:05a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2745	
9. DATE OF BIRTH Aug. 5, 1916		10. AGE (In years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto Salesman		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		17. SOCIAL SECURITY NO. 216-10-2138	
18. INFORMANT Mr John D Meagher		ADDRESS 6601 English Oak Rd	
19. CAUSE OF DEATH 011,94303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary tuberculosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-13-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/72	
24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Baltimore, Md	

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

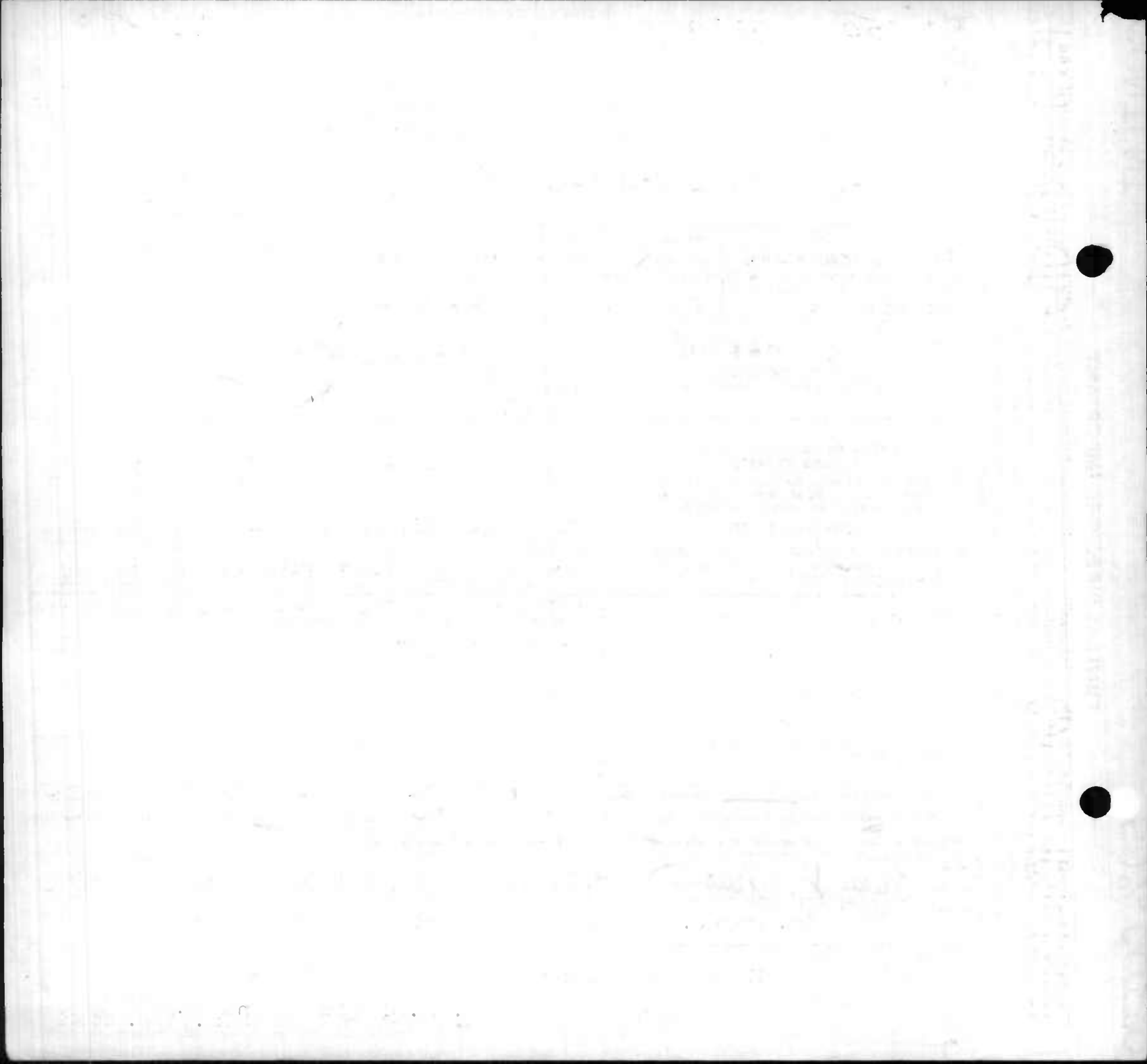
1918

1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

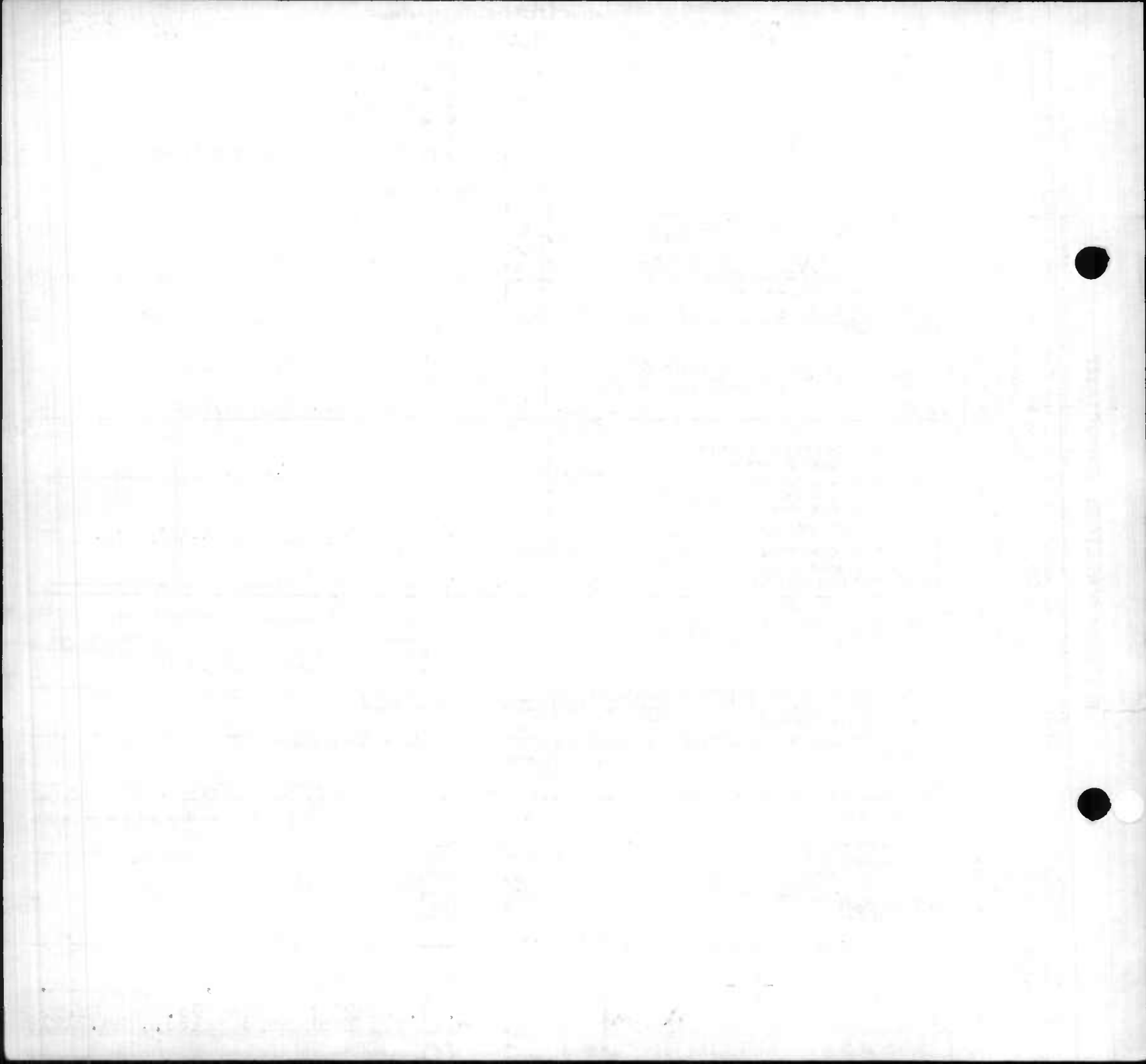
0-250 72 02678		72 02678		REG. NO. 72 02678	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCES M. OZMON		2. DATE AND HOUR OF DEATH MAR-15-1972 8 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2759		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL 44		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 4319 MARPLE HALL ROAD APT. 165	
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-01-98	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN S. MARTIN		14. MOTHER'S MAIDEN NAME MARIA E. STARR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 2-20-44-4117		17. INFORMANT JOHN H. SETH	
18. CAUSE OF DEATH 402X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ① ARTERIO SCLEROTIC VASCULAR DISEASE - 20 YEARS ② HYPERTENSION DISEASE ③ A - V BLOCK		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST 30 min.		(B) TERMINAL RENAL FAILURE 30 days	
		(C) DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE 45 days			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-2-72 to 3-15-72 that (I) (we) last saw the deceased alive on 3-14-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan J. Serrano M.D.		23B. DATE SIGNED MAR-15-1972		23C. PHYSICIAN'S NAME (Type) Dr. Juan J. Serrano	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-72		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore,		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
25D. ADDRESS 4805 York Road Balto., Md. 21212		25E. (City, town, or county)		25F. (State)	



FUNERAL DIRECTOR: IMPORTANT

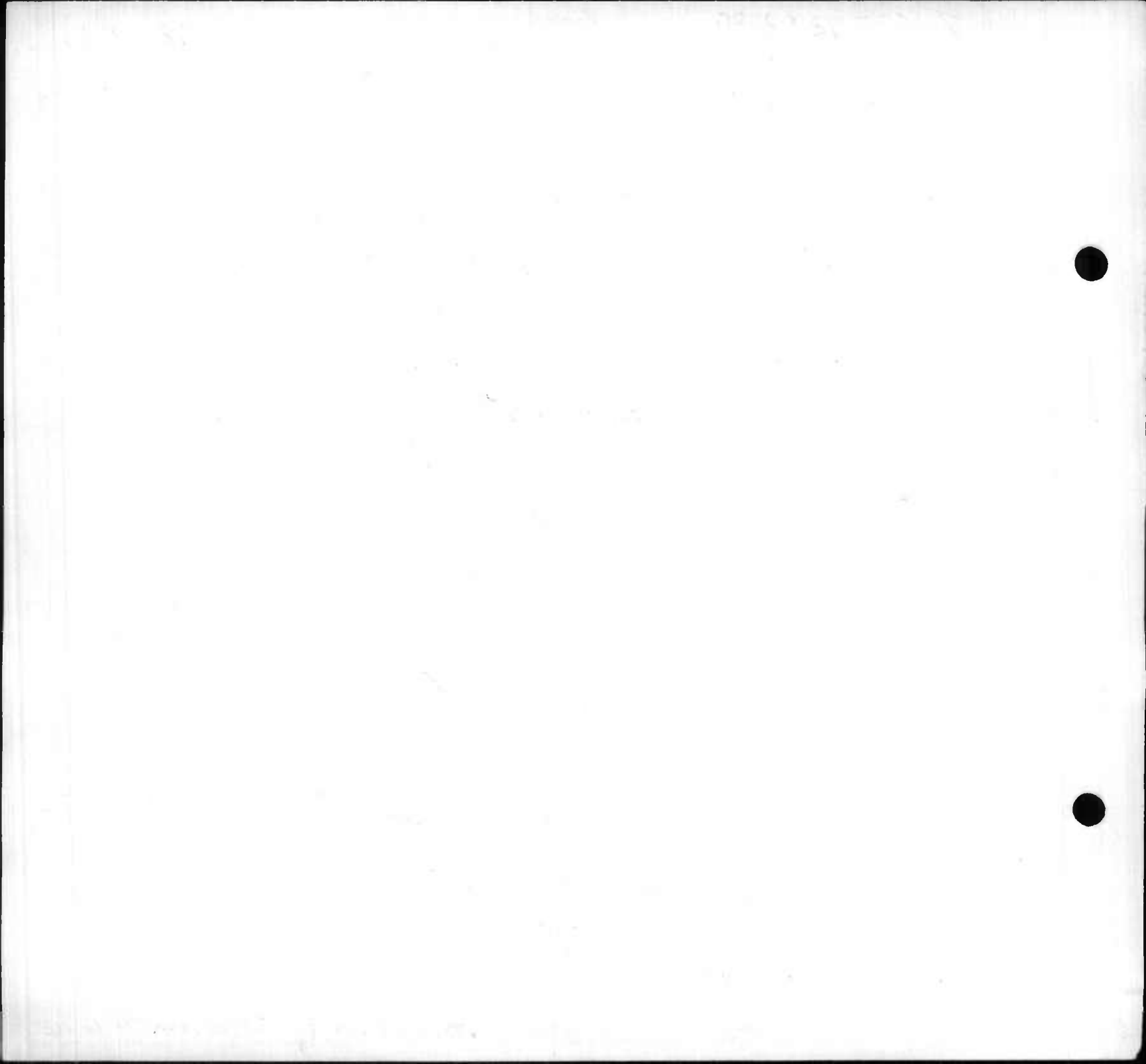
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>B-435 72 02679 CERTIFICATE OF DEATH X REG. NO. 72 02679</p>	
<p>BIRTH NO. _____</p>	
<p>1. NAME OF DECEASED (Type or Print) IRENE P. BALDWIN</p>	
<p>2. DATE AND HOUR OF DEATH MARCH 15, 1972 11:10p. M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL</p>	<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 10 OVERIDGE CRT.</p>
<p>5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11-12-1894 9. AGE (In years last birthday) 77 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 11. BIRTHPLACE (State or foreign country) FLORIDA 12. CITIZEN OF WHAT COUNTRY? USA</p>
<p>13. FATHER'S NAME SAMUEL PINNEY 14. MOTHER'S MAIDEN NAME IRENE MOONEY</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. R16-46-7088 17. INFORMANT SAMUEL C.P. BALDWIN ADDRESS (325 WOODLAWN RD)</p>	
<p>18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>	
<p>(A) IMMEDIATE CAUSE CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: (B) ACUTE ANTERIOR MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C) ARTERIO SCLEROSIS</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 03/13 19 72 to 03/15 19 72 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 03/15 19 72 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.</p>	
<p>23A. SIGNATURE C. U. M. 23B. DATE SIGNED 3/15/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) CESAR VILLAGAN 23D. ADDRESS 33rd. and Calvert St.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3-18-72 24C. NAME of CEMETERY or CREMATORY Chester 24D. LOCATION (City, town, or county) (State) Chestertown, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 16 1972 25B. NAME OF REGISTRAR Robert E. Talbot, M.D. 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

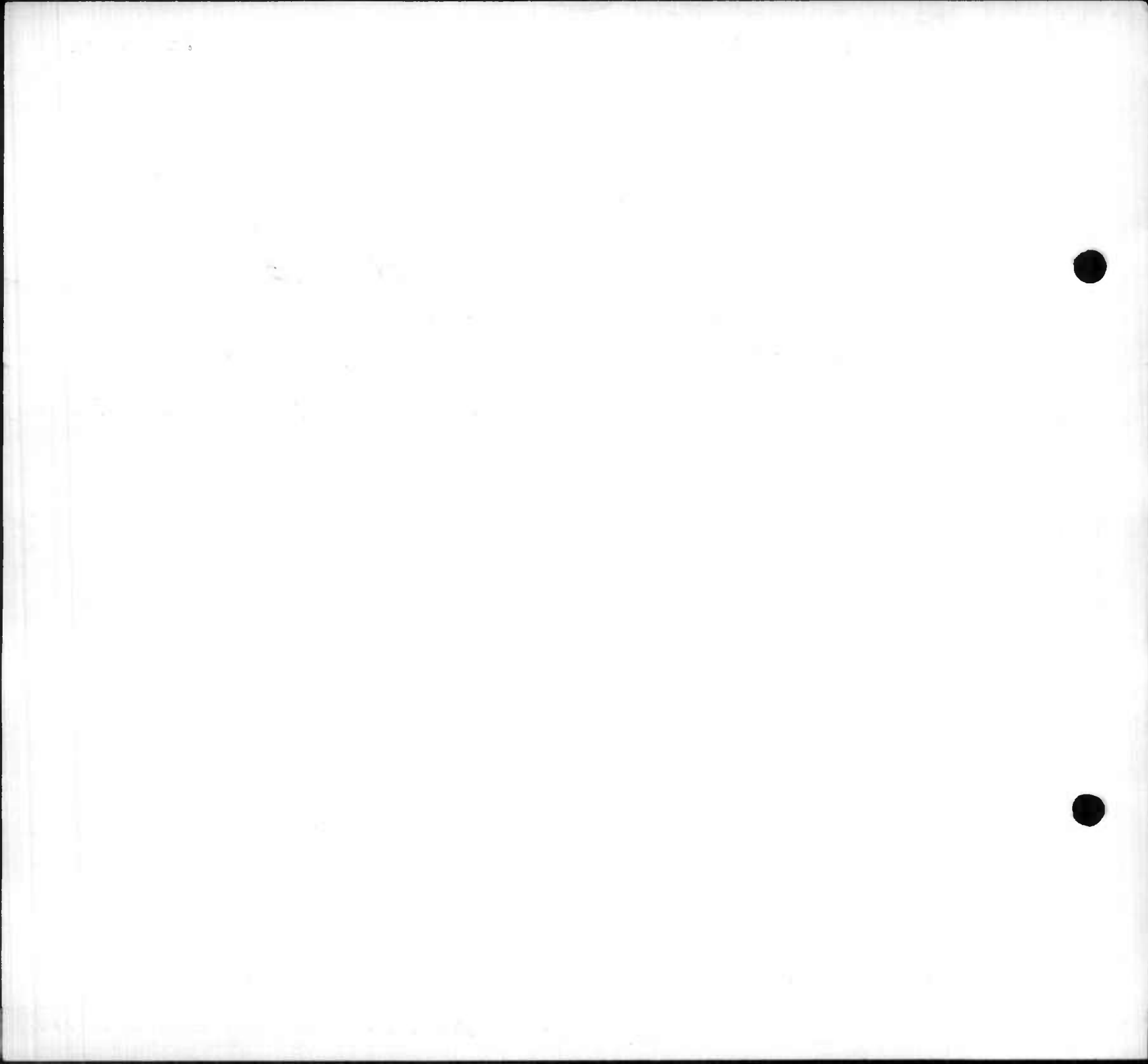
T-623 72 02680		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02680	
BIRTH NO. A.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Emma Hurston				3/13/72 5:58 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL Nursing Home				A. STATE Maryland		B. COUNTY 1511	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3900 HILTON Rd			
5. SEX Female		6. RACE BLACK		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-26-19	
						9. AGE (in years last birthday) 52 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 231-46-7533		17. INFORMANT Admission Record		ADDRESS	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) TERMINAL CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Terminal Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: ASC. V. Disease (B) CVA -		1 week ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension						?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/4 1972 to 3/13 1972 that (I) (we) last saw the deceased alive on 3/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Blum				23B. DATE SIGNED 3/13/72			
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) FREDERICKSBURG, VA.	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR WM E MARCH		ADDRESS 928 E NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

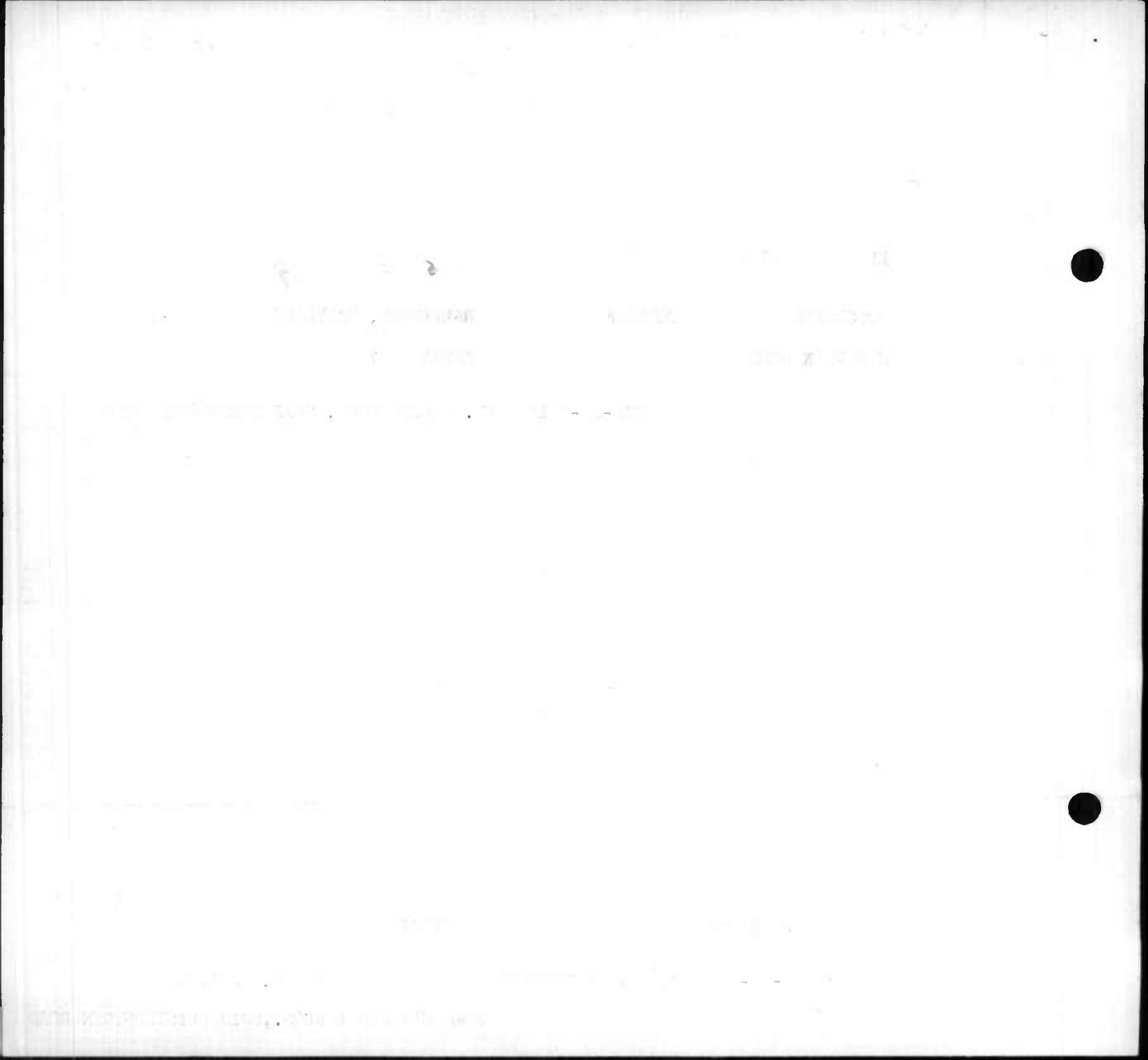
B-400		72 02681		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02681	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Bailey, (Stella) ESTELLE</u>			
2. DATE AND HOUR OF DEATH <u>3/15/72</u> <u>7-AM.</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1605</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>2303 Winchester St.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-6-99</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>ALFRED UPSHER</u>				14. MOTHER'S MAIDEN NAME <u>EMINIA BECKETT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>WALTER BAILEY JR. 2206 Roslyn Ave</u>	
18. <u>4199</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>C.H.F.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>R/o. MI 4 PULMONARY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>INFARCT.</u> (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <u>3/15</u> 19 <u>72</u> to <u>3/15</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>3/15</u> 19 <u>72</u> and that (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sein Lwin</u>				23B. DATE SIGNED <u>3/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Sein Lwin M.D.</u>	
23D. ADDRESS <u>LUTHERAN HOSPITAL</u>				23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-16-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEM PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>WM C MARCH</u>		25D. ADDRESS <u>928 E NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>C-500 72 02682 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 72 02682</p>			
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: right;">March 12, 1972 11:48 P.M.</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">Cohen, Florence</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE: Md. B. COUNTY: Baltimore</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">Sinai Hospital of Balt. Inc.</p>		<p>C. CITY OR TOWN D. INSIDE CITY LIMITS?</p> <p>Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>5. SEX 6. RACE</p> <p>FEMALE WHITE</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center;">HOUSEWIFE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="text-align: center;">AT HOME</p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="text-align: center;">BALTIMORE, MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="text-align: center;">USA</p>	
<p>13. FATHER'S NAME</p> <p style="text-align: center;">JOSEPH K HESS</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p style="text-align: center;">SAPRA ?</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;">NO</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;">216-52-5915</p>	
<p>17. INFORMANT</p> <p style="text-align: center;">MR. ELLIS COHEN, 6655 SANZO ROAD #21209</p>		<p>ADDRESS</p>	
<p>18. CAUSE OF DEATH</p> <p style="text-align: center;">I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">(A) IMMEDIATE CAUSE <u>Acute Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">(B) <u>Acute M.I.</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;">(C) _____</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p style="text-align: center;">1 day</p> <p style="text-align: center;">6 days</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p style="text-align: center;">NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from March 6 1972 to March 12 1972 that (I) (we) last saw the deceased alive on March 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="text-align: center;">Jack Pollack M.D.</p>		<p>23B. DATE SIGNED</p> <p style="text-align: center;">March 12, 1972</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="text-align: center;">JACK POLLACK</p>		<p>23D. ADDRESS</p> <p style="text-align: center;">SINAI</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="text-align: center;">BURIAL</p>		<p>24B. DATE</p> <p style="text-align: center;">3-14-72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="text-align: center;">HEBREW FRIENDSHIP</p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center;">BALTIMORE, MARYLAND</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="text-align: center;">MAR 17 1972</p>		<p>25B. NAME OF REGISTRAR</p> <p style="text-align: center;">SOL LEVINSON & BROS.</p>	
<p>25C. FUNERAL DIRECTOR</p> <p style="text-align: center;">SOL LEVINSON & BROS.</p>		<p>ADDRESS</p> <p style="text-align: center;">6010 REISTERSTOWN ROAD</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02683		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02683	
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">PAULINE SUSSMAN</div>			2. DATE AND HOUR OF DEATH MARCH 12, 1972 5:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;">LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTD 5300 B. COUNTY C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="text-align: center;">8604 GREY FOX ROAD</div>		
5. SEX Female	6. RACE Human	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1897 1898	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME ISAAC BERMAN			14. MOTHER'S MAIDEN NAME LENA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. STANLEY H. SUSSMAN, 3209 NERAK ROAD #21208	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from March 23 19 70 to March 12 19 72 that (X) (we) last saw the deceased alive on March 12 1972 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Theodore R. Reiff</i>			23B. DATE SIGNED March 13, 1972		23C. PHYSICIAN'S NAME (Type) THEODORE R. REIFF, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 3-14-72		24C. NAME OF CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL,
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02684	
BIRTH NO. 6-431		72 02684	
1. NAME OF DECEASED (Type or Print) GOLD BERG, ANNIE		2. DATE AND HOUR OF DEATH March 13, 1972 9:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Annie Hosp. of Baltimore, Inc.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2740	
		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 5901 Lemerale Drive Apt B,	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/1881
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years lost birthday) 90
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB JOSEPH KLOMPUS		14. MOTHER'S MAIDEN NAME MENUCHA RIFKIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-44-9337T	
17. INFORMANT MRS. ADA GERTZ, 3409 GLEN AVE., APT. D #21215		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro-Vascular accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic vascular disease	
		(B) DUE TO, OR AS A CONSEQUENCE OF: no. yrs.	
		(C) no. yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-11-72 to 3-13-72 that (I) (we) last saw the deceased alive on 3-13-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Veneranda C. Gerasmio, M.D.		23B. DATE SIGNED 3/13/72	
23C. PHYSICIAN'S NAME (Type) Veneranda C. Gerasmio, M.D.		23D. ADDRESS Annie Hosp. of Balt. Inc.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-14-72	
24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR SOE LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	

5901 DOVERDALE DR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-613		72 02685		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02685	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <u>Corinne Sharfatz</u>				2. DATE AND HOUR OF DEATH <u>3/13/72</u> <u>4 10</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Johns Hopkins Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hosp.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1190 W Northern Pkwy., APT. 229</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/28</u>	9. AGE (in years last birthday) <u>43</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HAMPTON, VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>PHILIP B. SHERMAN</u>				14. MOTHER'S MAIDEN NAME <u>GITA LEVY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>DR. GEORGE SHARFATZ, 1190 W. NORTHERN PKWY., #10</u>	
18. <u>II</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Resp Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic Breast Ca</u> (B) <u>Metastatic Breast Ca</u> (C) <u>None</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4 1/2 yrs</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>							
19A. DATE OF OPERATION <u>12/3/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>breast ca</u>		20A. AUTOPSY (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/1/72</u> 19 <u>72</u> to <u>3/13/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. R. Petracek</u>				23B. DATE SIGNED <u>3/12/72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. R. PETRACEK</u>	
23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>3-14-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MIKRO KODESH</u>		24D. LOCATION (City, town, or county) (State) <u>BOWLEYS LANE, BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1972</u>		25B. NAME OF REGISTRAR <u>R. G. E. Jones, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			

AT THE

OFFICE OF THE

CLERK OF THE

COURT

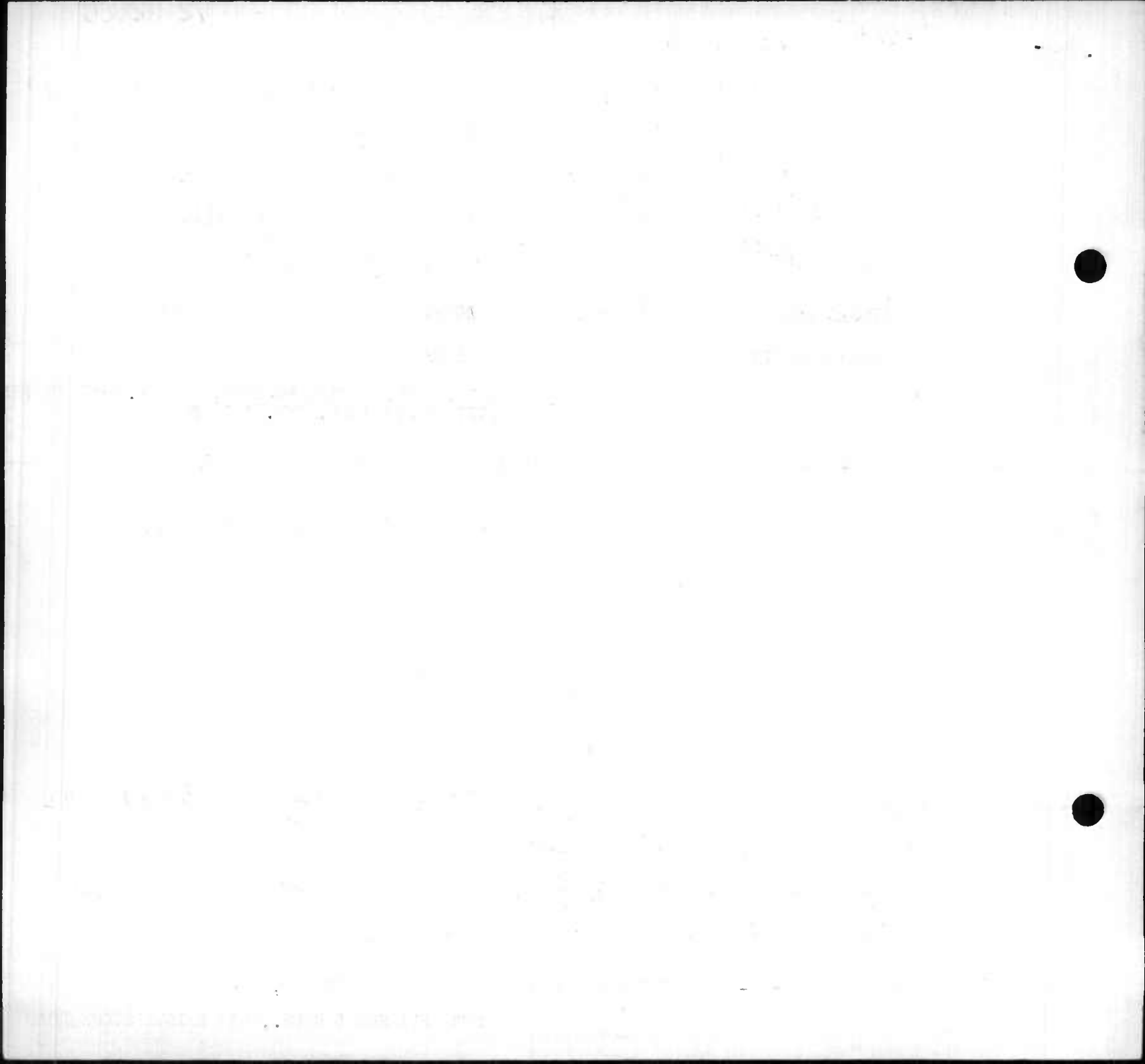
IN THE

RECORDS

OF THE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-265 72 02686		BALTIMORE CITY HEALTH DEPARTMENT		72 02686	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Abraham Negrin		2. DATE AND HOUR OF DEATH 3-14-72 9:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hosp. of Balt. Baltimore Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt. City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4003 Fernhill Rd.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-04	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) EGYPT	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ANGELO NEGRIN			
14. MOTHER'S MAIDEN NAME SIMCA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HEBREW FREE BURIAL SOCIETY, c/o MR. MOSE MORRIS 3737 CLARKS LANE, APT. 101 #21215			
18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congestive Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-13 19 72 to 3-14 19 72 that (I) (we) last saw the deceased alive on 3-14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joshua Frankel		23B. DATE SIGNED 3-14-72		23C. PHYSICIAN'S NAME (Type) Joshua Frankel M.D.	
23D. ADDRESS 3906 Fords Lane		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 3-15-72		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS SOE LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02687	
4-552		72 02687		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>John W Henningsen</u>		2. DATE AND HOUR OF DEATH <u>3/13/72</u> <u>11</u> <u>40</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Md. General Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Glen Burnie, Md</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>110 Eastern St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/04</u>	9. AGE (In years last birthday) <u>67</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur - Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jacob Henningsen</u>			
14. MOTHER'S MAIDEN NAME <u>Meta Behrens</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>213096632</u>		17. INFORMANT <u>Wife - Emily Henningsen - same as 4.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Probable Metastatic Carcinoma of Lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/6/72</u> 19 <u>72</u> to <u>3/13</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>3/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Willard P. Amoss M.D.</u>		23B. DATE SIGNED <u>3/13/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Willard P. Amoss M.D.</u>	
23D. ADDRESS <u>Md. General Hosp</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>17 March 72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Howard County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1972</u>		25B. NAME OF REGISTRAR <u>Kirkley Funeral Home</u>		25C. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>	

(2)

SECRET - SECURITY INFORMATION

SECRET

SECRET

SECRET

SECRET

SECRET - SECURITY INFORMATION

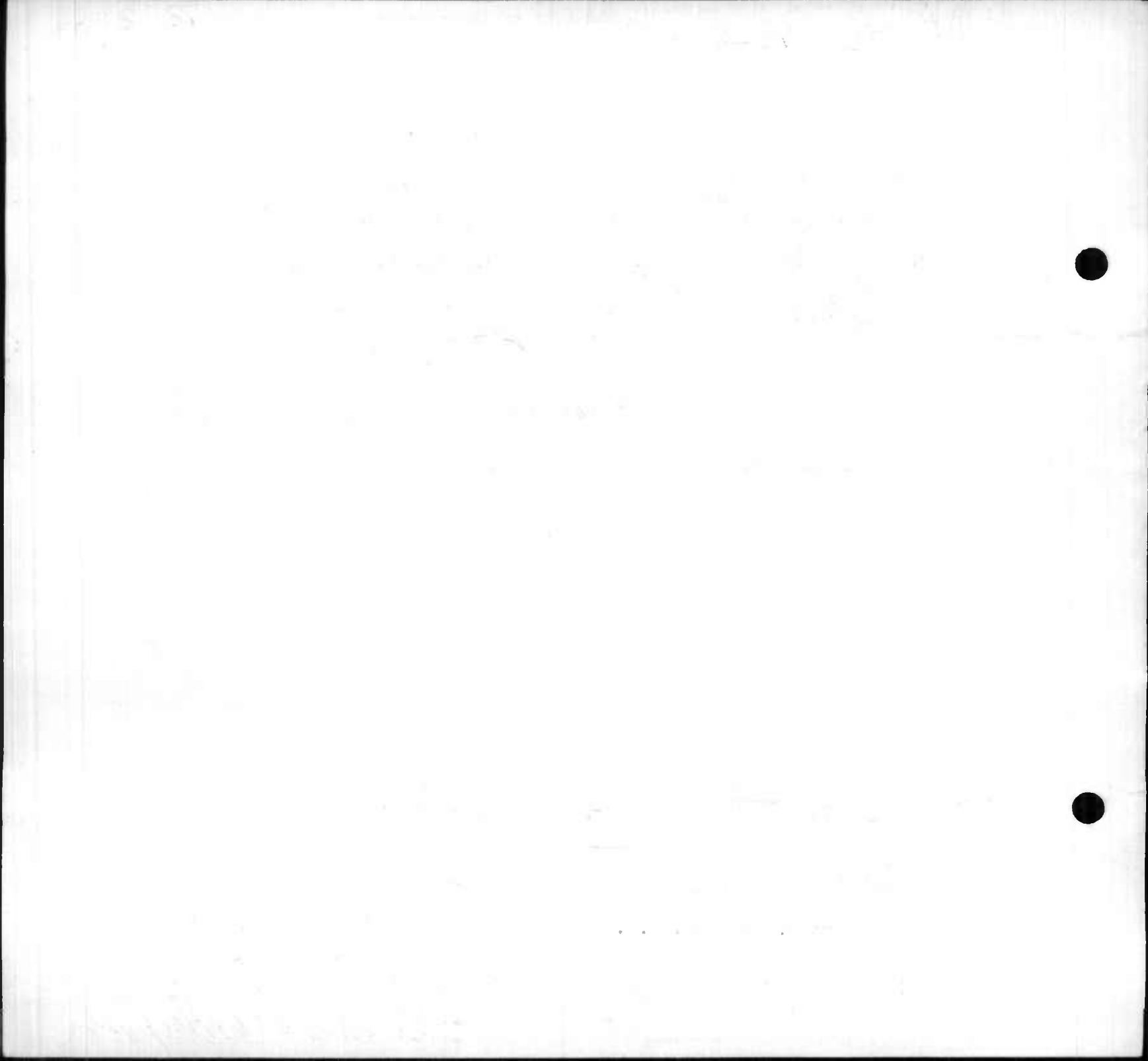
SECRET - SECURITY INFORMATION

SECRET - SECURITY INFORMATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

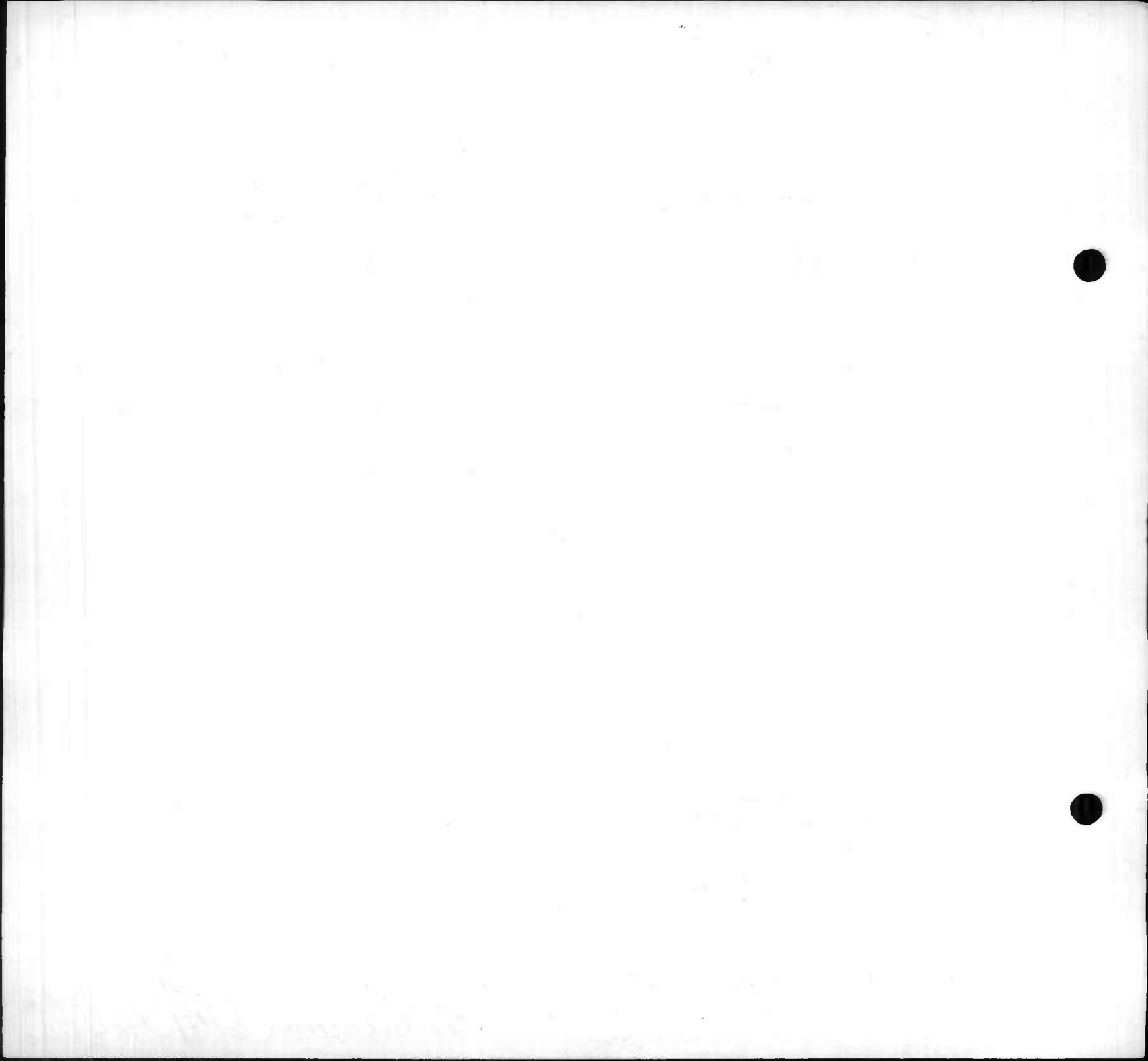
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
4-200		72 02688		72 02688	
1. NAME OF DECEASED (Type or Print) HOZEY, Howard			2. DATE AND HOUR OF DEATH 3/12/72 15:20 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE PA B. COUNTY V 35		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOUSE IN The Pines Bel Air 5837 Bel Air Rd Baltimore Md 21206			C. CITY OR TOWN Philadelphia		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/15/1886		9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Seaman		11. BIRTHPLACE (State or foreign country) Philadelphia	
13. FATHER'S NAME Joe			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 197-03-1062		17. INFORMANT Joe Palacio	
18. 4/12/41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE yes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Glaucoma			(B) Glaucoma DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE yes		(C) Glaucoma DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE yes
19A. DATE OF OPERATION 3/12/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1/26/1968 to 3/12/1972 that (I) (we) last saw the deceased alive on 3/12/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			23B. DATE SIGNED 3/13/72		23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 3/13/72		24C. NAME of CEMETERY or CREMATORY Resurrection of our Lord
24D. LOCATION Cornwell Pa			25A. DATE REC'D BY HEALTH DEPT. NAR 17 1972		25B. NAME OF REGISTRAR Robert J. Baker
25C. FUNERAL DIRECTOR W. J. Williams			25D. ADDRESS 6067 Hays Rd		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 02689</u>	
E-463 BIRTH NO. <u>72 02689</u>		1. NAME OF DECEASED (Type or Print) <u>ALMA EULERT</u>				2. DATE AND HOUR OF DEATH <u>3/13/72 8:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Gould Nur Home</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>807</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1743 Oliver St.</u>			
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/7/92</u> 9. AGE (In years last birthday) <u>79</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>—</u>				13. FATHER'S NAME <u>Henry Horst</u>			
14. MOTHER'S MAIDEN NAME <u>R. Sanders</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Rolanda Culbert</u> ADDRESS <u>4001 Deepwood Rd</u>			
18. <u>4/12/72</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,							
(A) IMMEDIATE CAUSE <u>Coronary atherosclerosis, embolism, infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Renal Hypertension</u>							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>—</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>					
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>1/3/72</u> to <u>3/13/72</u> that (I) (we) last saw the deceased alive on <u>3/13/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Albert B. Brady</u>				23B. DATE SIGNED <u>3/13/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>—</u>				23D. ADDRESS <u>—</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/17/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bethesda Nat.</u>			
24D. LOCATION (City, town, or county) (State) <u>Bethesda Pa.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1972</u>					
25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>William Collet</u> ADDRESS <u>Harford</u>					



1
D-553

M-532

72 02690

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02690

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARRIE D. MINDS (DEMINDS)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 15, 1972 3:50 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour March 15, 1972 3:50 P.	
6. SEX Female		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-15-86		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 85		E. STREET AND NUMBER 1419 Myrtle Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		13. FATHER'S NAME John Edwards	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Lucy Edwards	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N/a		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Viola Hawkins		ADDRESS Apt 615 1102 Druid Hill Ave	
19. E890X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Smoke inhalation ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Conflagration OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 3-18-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1419 Myrtle Avenue		22F. HOW DID INJURY OCCUR? Found in room with burning mattress	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-14-72 9:30 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 16, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72	
24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972		25B. NAME OF REGISTRAR Robert F. H. 1701 Laurens St.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701 Laurens St.		25D. ADDRESS	

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

10-17-66

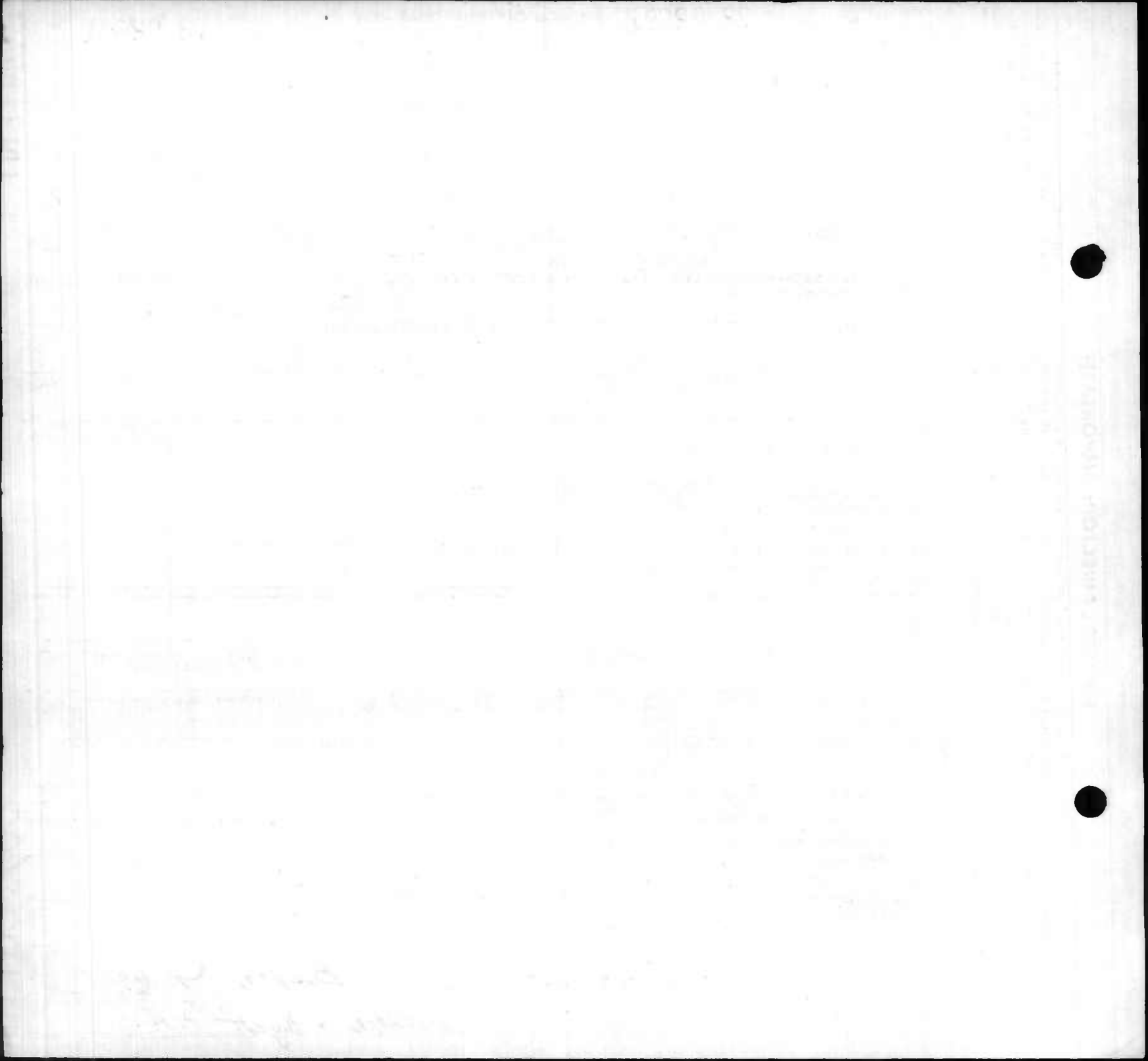
10-17-66

10-17-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02691	
CERTIFICATE OF DEATH			
BIRTH NO. R-163			
1. NAME OF DECEASED (Type or Print) Robertson, Robert		2. DATE AND HOUR OF DEATH March 15, 1972 3:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY 1509	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hosp.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3907 Carlye Ave Carlsale	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-21 9. AGE (In years last birthday) 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
13. FATHER'S NAME Rev James H. Roberson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Mamie G. Roberson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-44-7968	
		17. INFORMANT Mrs Elva Roberson ADDRESS 3907-Carlye Ave	
18. 4-36-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CVA, Lt. hemiparesis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: — (C) —	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-13 19 72 to 3-15 19 72 that (I) (we) last saw the deceased alive on 3-15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE V. Chitraplee		23B. DATE SIGNED 3-15-72	
23C. PHYSICIAN'S NAME (Type) V. Chitraplee		23D. ADDRESS Provident Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-72	
24C. NAME OF CEMETERY OR CREMATORY Balto Nat. Cem		24D. LOCATION (City, town, or county) (State) Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972		25B. NAME OF REGISTRAR Blaise J. Baker, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F.A.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02692	
P-160 72 02692		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Pfeifer		2. DATE AND HOUR OF DEATH March 15, 1972 8:00 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 410 S. Highland Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2611 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 410 S. Highland Avenue			
5. SEX Fem.	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/1893	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Hughes		14. MOTHER'S MAIDEN NAME Catherine Boyle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Jack Pfeifer	
18. 149X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the neck & throat with metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Arteriosclerotic Heart Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from JANUARY 1969 to MARCH 15, 1972 , that (I) (we) last saw the deceased alive on MARCH 13, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Melito M. Torres, M.D.		23B. DATE SIGNED MAR 17, 1972		23C. PHYSICIAN'S NAME (Type) MELITO M. TORRES, M. D. 441 S. ELLWOOD AVENUE	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/72	
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972	
25B. NAME OF REGISTRAR Robert E. Tabor, M.D.		25C. FUNERAL DIRECTOR Joseph N. Zannino		25D. ADDRESS 263 S. Conkling Street	

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02693	
H-163 72 02693					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) MATTHEW J. HUBERT MATTHEW J. HUBERT (RACHUBINSKI)			2. DATE AND HOUR OF DEATH 3-15-72 7:05 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital, Inc.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 202		
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/2/1902 9. AGE (In years last birthday) 69		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile setter			10B. KIND OF BUSINESS OR INDUSTRY Stone Mason		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME MICHAEL RACHUBINSKI			14. MOTHER'S MAIDEN NAME SUSANNE GRYGLIK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212 03 0864		
17. INFORMANT JOSE HUBERT			ADDRESS 314 S. ANN ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15-7-9 I Carcinoma pancreas Massive GI hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/24 19 72 to 3/15 19 72 , that (I) (we) last saw the deceased alive on 3 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael V. Edelstein M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Michael V. Edelstein				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3/20/72		24C. NAME OF CEMETERY or CREMATORY HOLY ROSA FY CEMETERY	
24D. LOCATION (City, town, or county) (State) DUNDALK MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972			
25B. NAME OF FUNERAL DIRECTOR JOHN M. WEAVER & SONS INC.		25C. ADDRESS 4015 CHESTER ST			

11/1

11/1

11/1

11/1

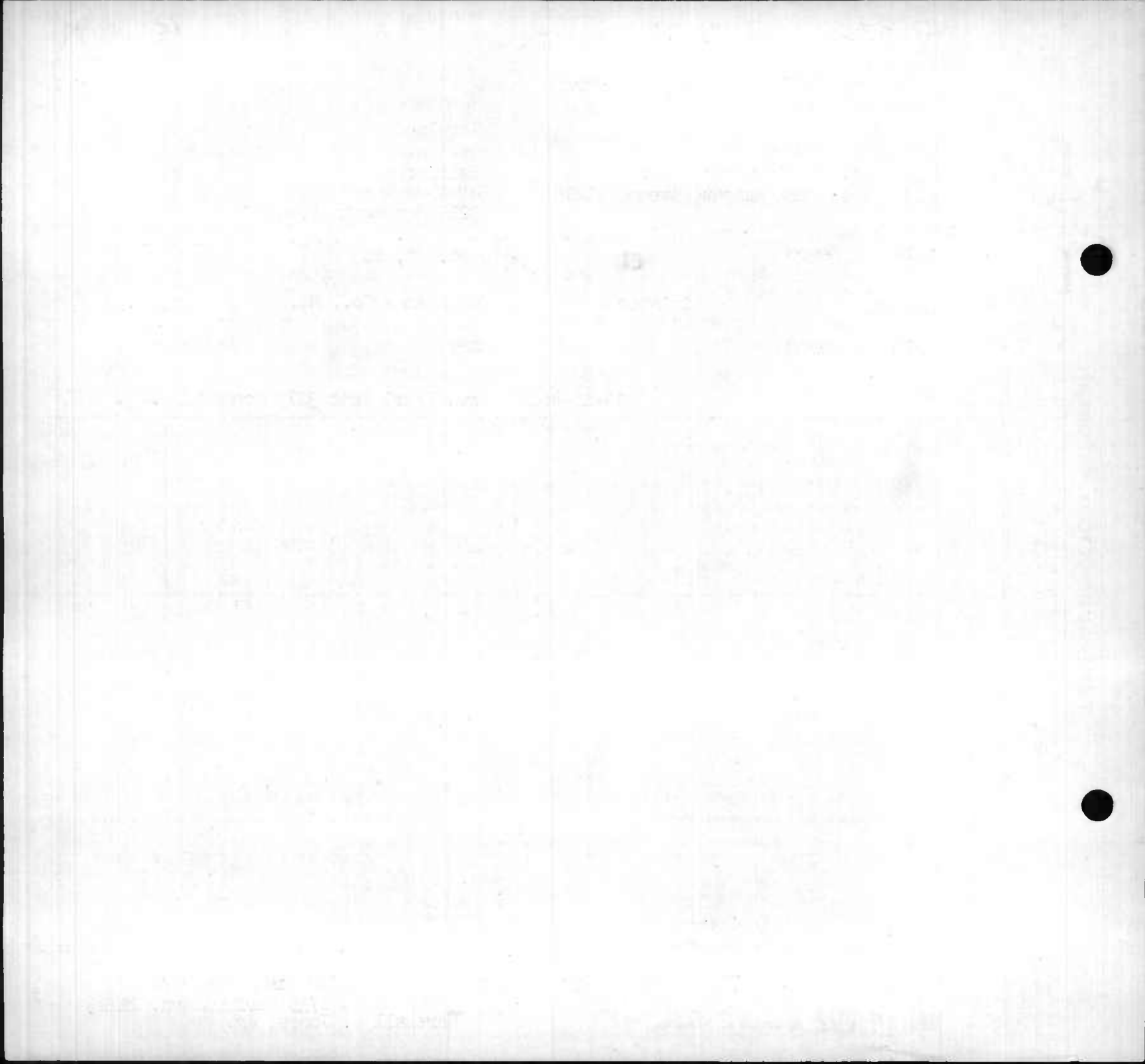
11/1

11/1 11/1 11/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

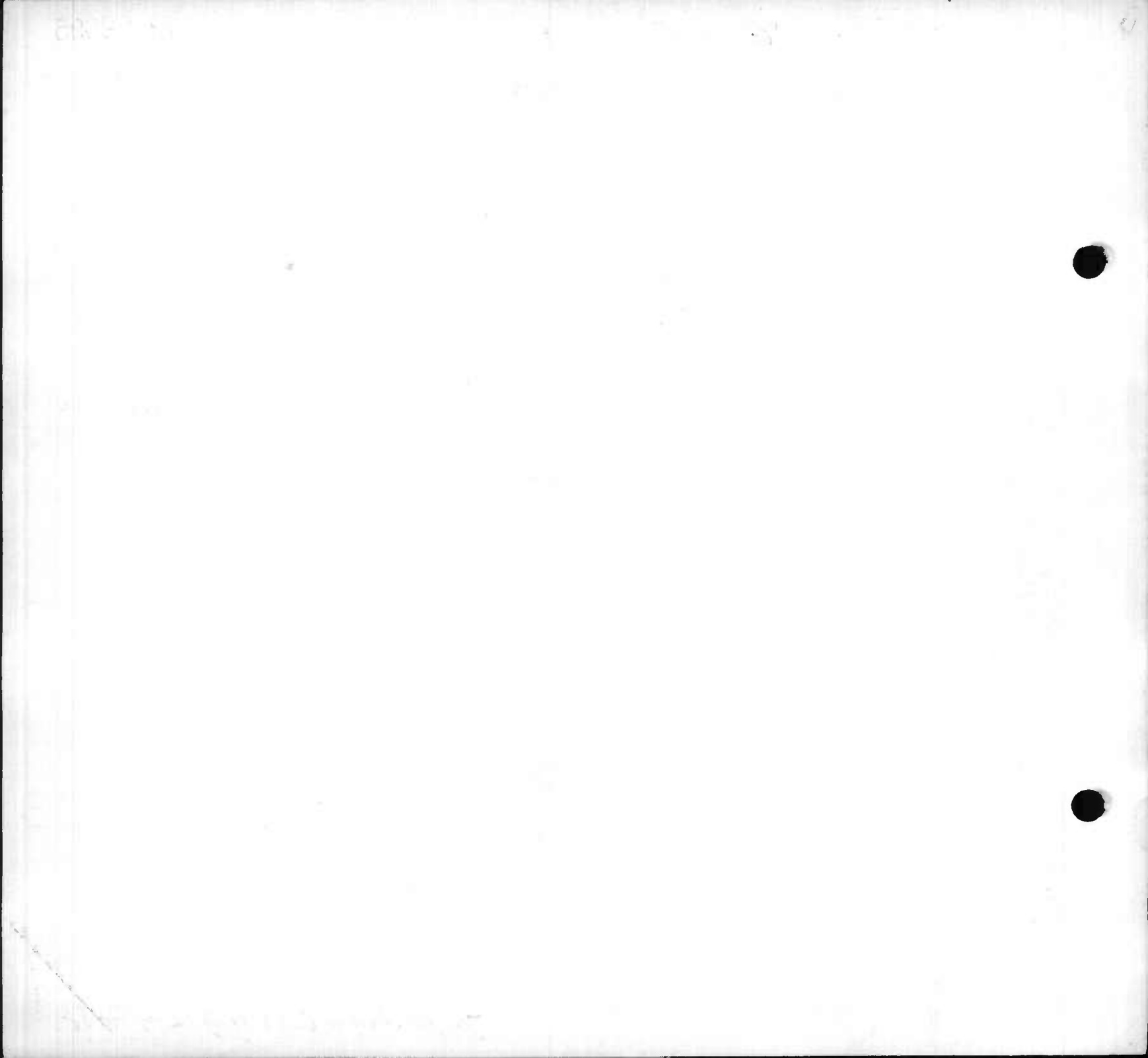
<p>A-536 72 02694</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02694</p>					
<p>BIRTH NO. _____</p>				<p>1. NAME OF DECEASED (Type or Print) Rev. William H. Anderson</p>				<p>2. DATE AND HOUR OF DEATH 3-16-72 9:15 A. M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1537</p>				<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Mt. Sinai Nursing Home 4613 Park Heights Avenue 21215</p>				<p>E. STREET AND NUMBER 3219 Mondawmin Avenue</p>							
<p>5. SEX Male</p>		<p>6. RACE Negro</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH Sept. 20, 88</p>		<p>9. AGE (In years last birthday) 83</p>		<p>10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY Minister</p>		<p>11. BIRTHPLACE (State or foreign country) Queen Anne Co., Md.</p>				<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Frisby Anderson</p>				<p>14. MOTHER'S MAIDEN NAME Mary Anderson</p>							
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) no</p>				<p>16. SOCIAL SECURITY NO. 214-16-4664</p>		<p>17. INFORMANT Mrs. Pearl Teat</p>				<p>ADDRESS 3219 Mondawmin Ave. 21216</p>	
<p>18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Emphysema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Smoking</p>				<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Smoking</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years</p>			
				<p>(B) DUE TO, OR AS A CONSEQUENCE OF: Bilateral AKA</p>				<p>years</p>			
				<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Bilateral AKA</p>				<p>years</p>			
<p>19A. DATE OF OPERATION 3/8</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>							
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>							
<p>22. I certify that (I) (this hospital) attended the deceased from 6/4 72 19 41 to 3/16 72 19 42, that (I) (we) last saw the deceased alive on 3/8 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
<p>23A. SIGNATURE [Signature]</p>								<p>23B. DATE SIGNED 3/16/72</p>			
<p>23C. PHYSICIAN'S NAME (Type) V A SH</p>								<p>23D. ADDRESS 206 S. Gilman Blvd.</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3-20-72</p>		<p>24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972</p>				<p>25B. NAME OF REGISTRAR Robert E. Jones, Jr.</p>				<p>25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

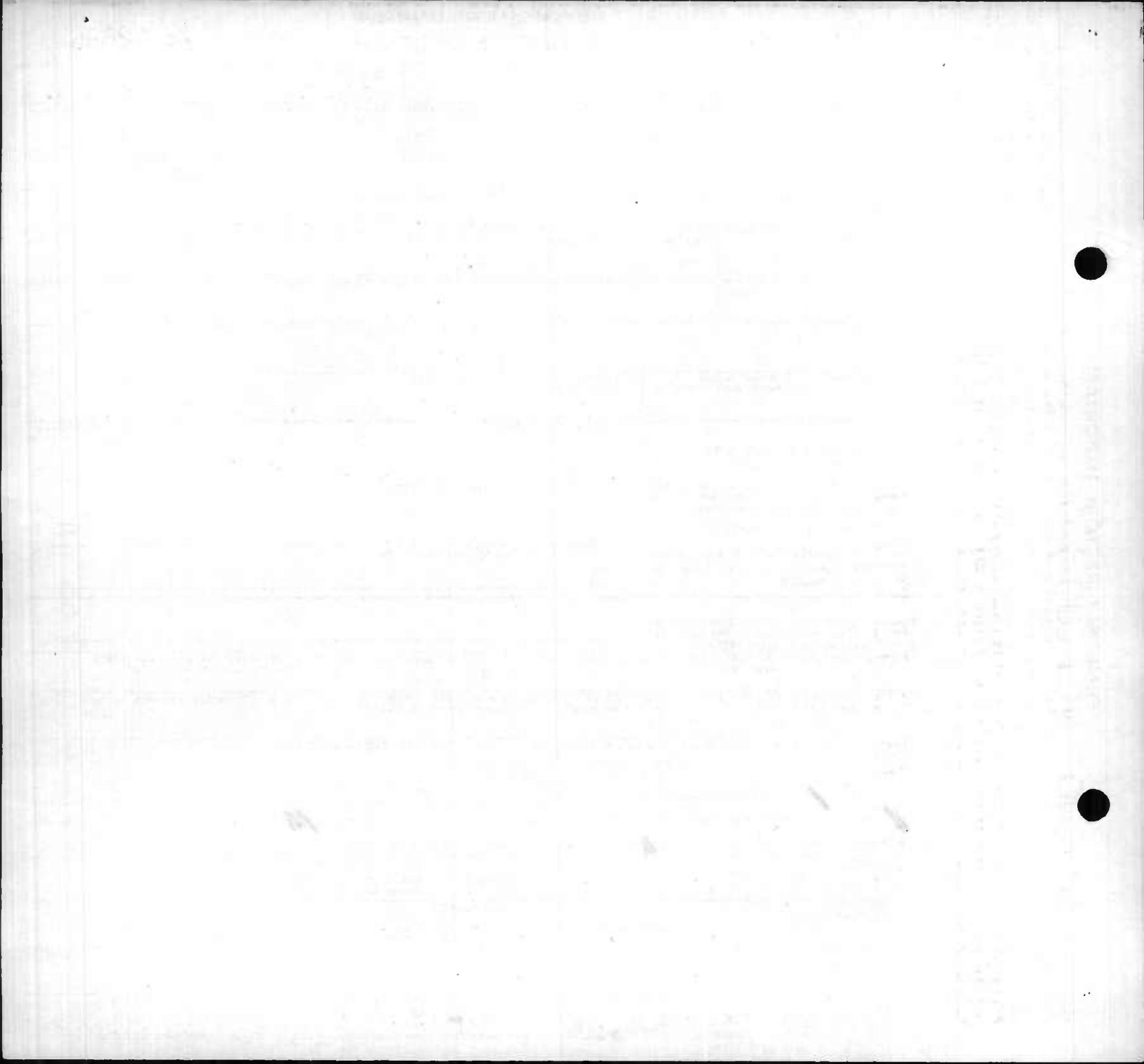
G-530		72 02695		BALTIMORE CITY HEALTH DEPARTMENT		72 02695	
CERTIFICATE OF DEATH				BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) MR. HARRY GANTT.				2. DATE AND HOUR OF DEATH 3/14/72 19.45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2802			
5. SEX M				6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawson Longmorton				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 12-25-08 9. AGE (In years last birthday) 63	
13. FATHER'S NAME Unkown				14. MOTHER'S MAIDEN NAME Unkown		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 911-18-7922		12. CITIZEN OF WHAT COUNTRY? USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 513X1				CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiorespiratory Failure. DUE TO, OR AS A CONSEQUENCE OF: (B) Lung Abscess. DUE TO, OR AS A CONSEQUENCE OF: (C) C.V.A.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/1 19 72 to 3/14 19 72 that (I) (we) last saw the deceased alive on 3/14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Mitra. MD				23B. DATE SIGNED 3/14/72.		23C. PHYSICIAN'S NAME (Type) DR RUPAK MITRA. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/20/72		24C. NAME OF CEMETERY or CREMATORY mt Armon	
24D. LOCATION (City, town, or county) (State) Baltimore				25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972			
25B. NAME OF REGISTRAR John J. Smith, M.D.				25C. FUNERAL DIRECTOR John J. Smith 636 4912			
25D. ADDRESS 636 4912							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

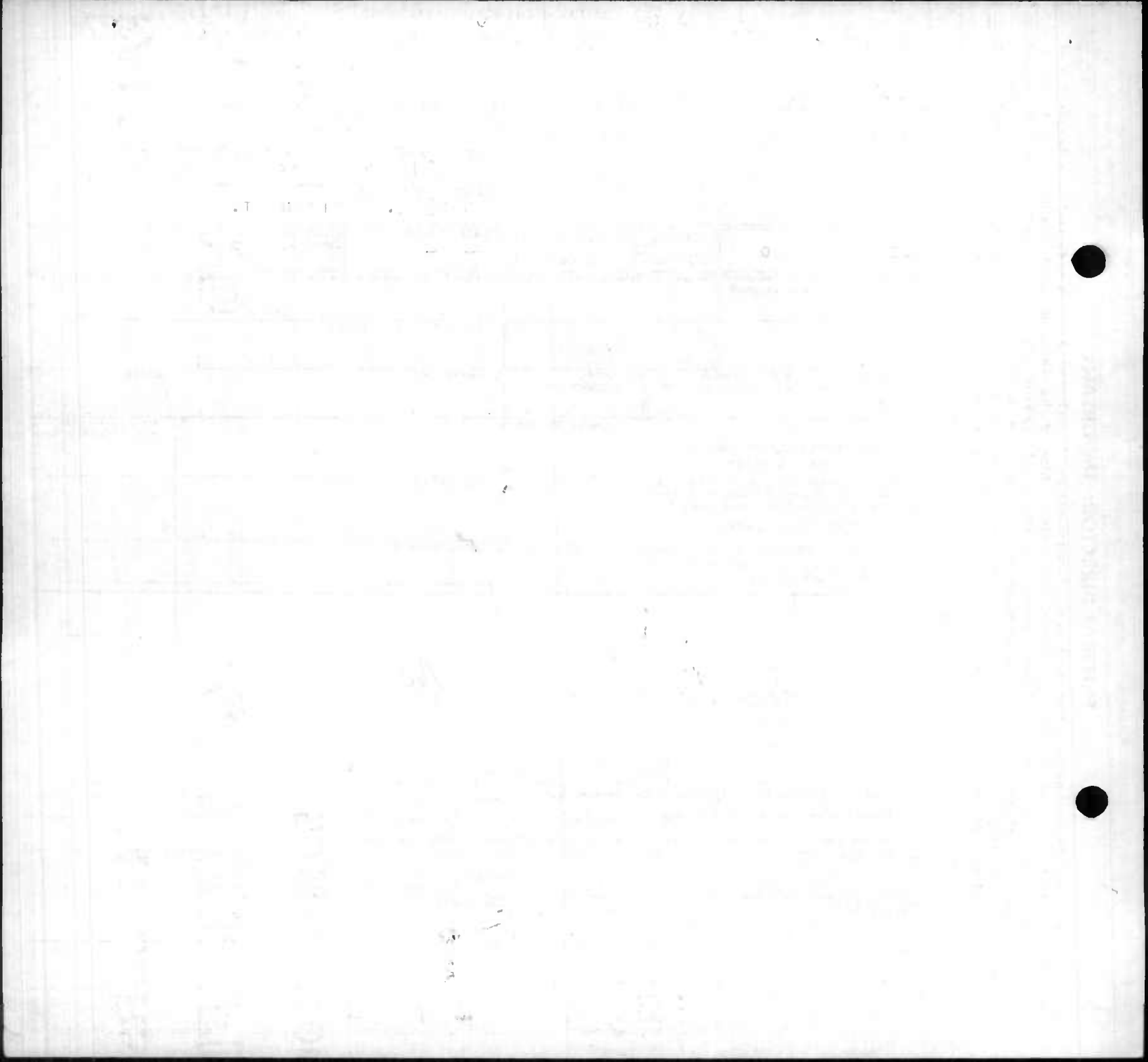
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02696	
1. NAME OF DECEASED <small>(Type or Print)</small> <div style="text-align: center; font-size: 1.2em;">JONES, Freely</div>		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 3/15/72 5:00 a.m. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION <div style="text-align: center; font-size: 1.2em;">The Johns Hopkins Hospital</div> </div> <div> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION </div> </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE <div style="text-align: center; font-size: 1.2em;">Maryland</div> </div> <div> B. COUNTY <div style="text-align: center; font-size: 1.2em;">704</div> </div> </div> <div style="display: flex; justify-content: space-between;"> <div> C. CITY OR TOWN <div style="text-align: center; font-size: 1.2em;">Baltimore</div> </div> <div> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div> </div> <div> E. STREET AND NUMBER <div style="text-align: center; font-size: 1.2em;">931 N. Durham Street</div> </div>			
5. SEX <div style="text-align: center; font-size: 1.2em;">Male</div>	6. RACE <div style="text-align: center; font-size: 1.2em;">Negro</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">4/02/12</div>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Fork Lifter</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 1.2em;">Beth. Steel</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 1.2em;">N. Carolina</div>	
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">?</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">Martha</div>			
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <div style="text-align: center; font-size: 1.2em;">No</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">245-032930</div>		17. INFORMANT <div style="text-align: center; font-size: 1.2em;">Katie Mae Jones</div>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <div style="text-align: center; font-size: 1.2em;">4/10/72 I</div> <p><small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small></p> <div style="text-align: center; font-size: 1.2em;">Ventricular Fibrillation</div>		CAUSE OF DEATH <div style="text-align: center; font-size: 1.2em;">MI</div>			
19. DATE OF OPERATION <div style="text-align: center; font-size: 1.2em;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) <div style="text-align: center; font-size: 1.2em;">NO</div>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 	
21D. TIME OF INJURY (APPROX.) <div style="display: flex; justify-content: space-between;"> <div> (Month) </div> <div> (Day) </div> <div> (Year) </div> <div> (Hour) </div> </div>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <div style="text-align: center; font-size: 1.2em;">March 9</div> 19 <div style="text-align: center; font-size: 1.2em;">72</div> to <div style="text-align: center; font-size: 1.2em;">March 15</div> 19 <div style="text-align: center; font-size: 1.2em;">72</div> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <div style="text-align: center; font-size: 1.2em;">March 15</div> 19 <div style="text-align: center; font-size: 1.2em;">72</div> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <div style="text-align: center; font-size: 1.5em;">RD Kramer MD</div>				23B. DATE SIGNED <div style="text-align: center; font-size: 1.2em;">4/15/72</div>	
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">Robert D. Kramer, M.D.</div>		23D. ADDRESS <div style="text-align: center; font-size: 1.2em;">The Johns Hopkins Hospital</div>			
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		24B. DATE <div style="text-align: center; font-size: 1.2em;">3-18-72</div>		24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center; font-size: 1.2em;">Arbutus Mem. Park</div>	
24D. LOCATION (City, town, or county) <div style="text-align: center; font-size: 1.2em;">Arbutus, Md.</div>		24E. STATE <div style="text-align: center; font-size: 1.2em;">Md.</div>			
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center; font-size: 1.2em;">MAR 17 1972</div>		25B. NAME OF REGISTRAR <div style="text-align: center; font-size: 1.2em;">Milton L. Erickson</div>		25C. FUNERAL DIRECTOR <div style="text-align: center; font-size: 1.2em;">1129 N. Carolina</div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02697</u>	
BIRTH NO. <u>72 02697</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Johnnie Samuel</u>			2. DATE AND HOUR OF DEATH <u>3/14/72</u> <u>12:30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1002</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1213 E. MADISON ST.</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-09</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Samuel</u>			14. MOTHER'S MAIDEN NAME <u>Anna Edward</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-4548</u>	17. INFORMANT <u>James M. Samuel</u>		ADDRESS <u>714 N. Eden St.</u>
18. <u>486X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CUA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>72</u> to <u>3/14</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/14</u> 19 <u>72</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Harold Herderman, MD</u>				23B. DATE SIGNED <u>3/14/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. HAROLD HERDERMAN MD</u>				23D. ADDRESS <u>Johns Hopkins Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-20-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem Park</u>	
24D. LOCATION <u>Arbutus, Md.</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 17 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, MD</u>		25C. FUNERAL DIRECTOR <u>W. H. T. E. Elickson</u>	
ADDRESS <u>1129 N. Carolina</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

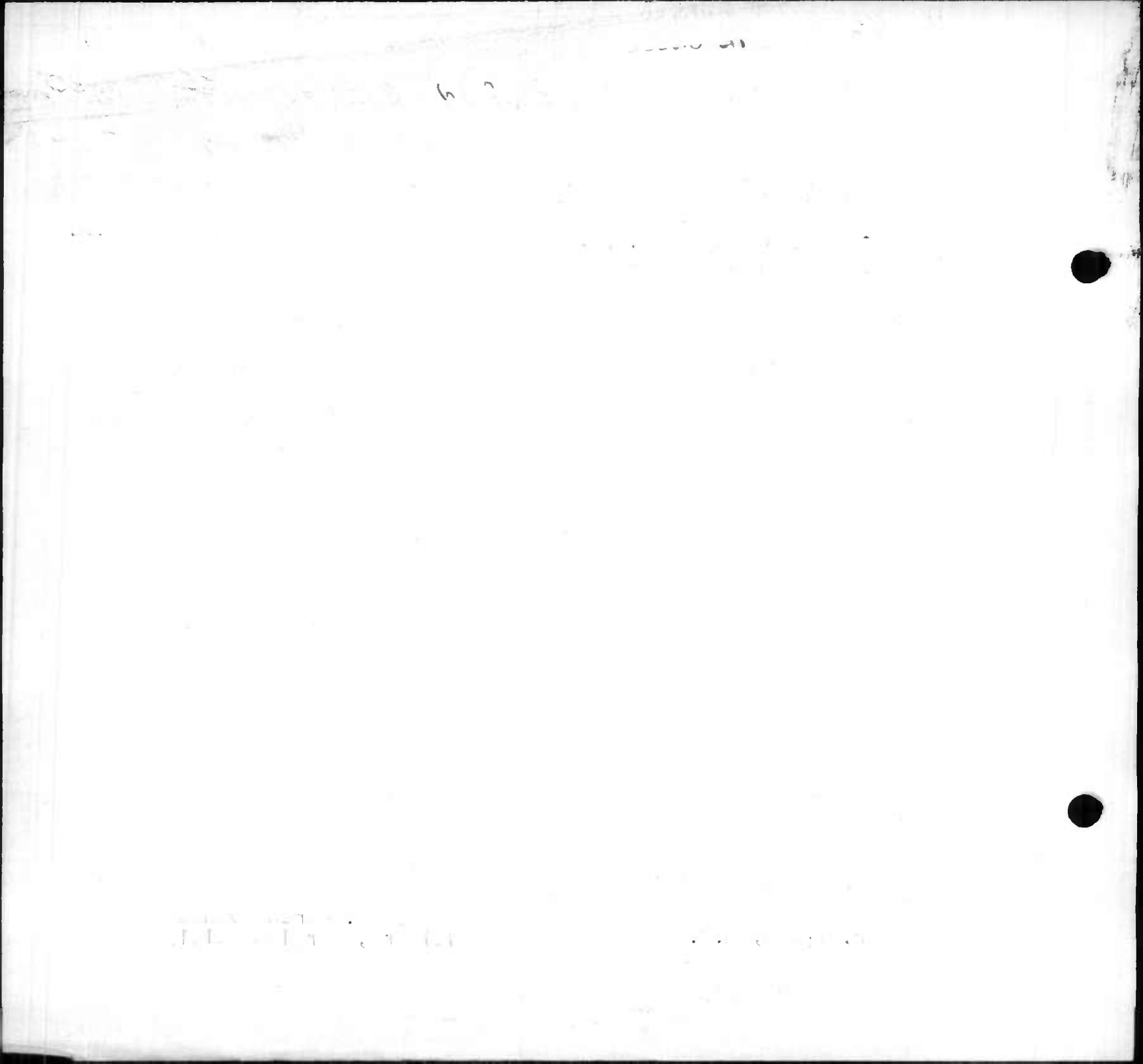
T-524		72 02698		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02698	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lillian Tingle</i>				2. DATE AND HOUR OF DEATH <i>3-9-72 10¹⁰ A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>MD</i>		B. COUNTY <i>1547</i>	
<i>90 Windsor Nursing Home</i>		<i>3025 Windsor Ave</i>		C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3025 Windsor Ave</i>							
5. SEX <i>F</i>	6. RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 30, 1887</i>	9. AGE (In years last birthday) <i>84</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Balto MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Lloyd Stewart</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth Kella</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>214-38-7580-A</i>		17. INFORMANT <i>Mrs. Pennington</i>		
			ADDRESS <i>1715 Westwood Ave</i>				
18. <i>412.1</i>			CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Decompensation</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>ASCVD Diabetes Mellitus</i>				
			(C) <i>Chronic Brain Syndrome</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-8-1970</i> to <i>3-9-1972</i> , that (I) (we) last saw the deceased alive on <i>3-8-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. I. Baykaler, M.D.</i>				23B. DATE SIGNED <i>3-9-72</i>			
23C. PHYSICIAN'S NAME (Type) <i>A. I. BAYKALER M.D.</i>				23D. ADDRESS <i>301 Mc Mechen St. Balto. 21217</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>B 3/13/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bentley Cr.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 17 1972</i>		25B. NAME OF REGISTRAR <i>J. E. ...</i>		25C. FUNERAL DIRECTOR <i>J. E. ...</i>			
				ADDRESS <i>2222 Windsor Ave</i>			

N.H. unable to obtain date of
adm. & prev. address at
time of phone call. Promised
to call back with info.
J

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

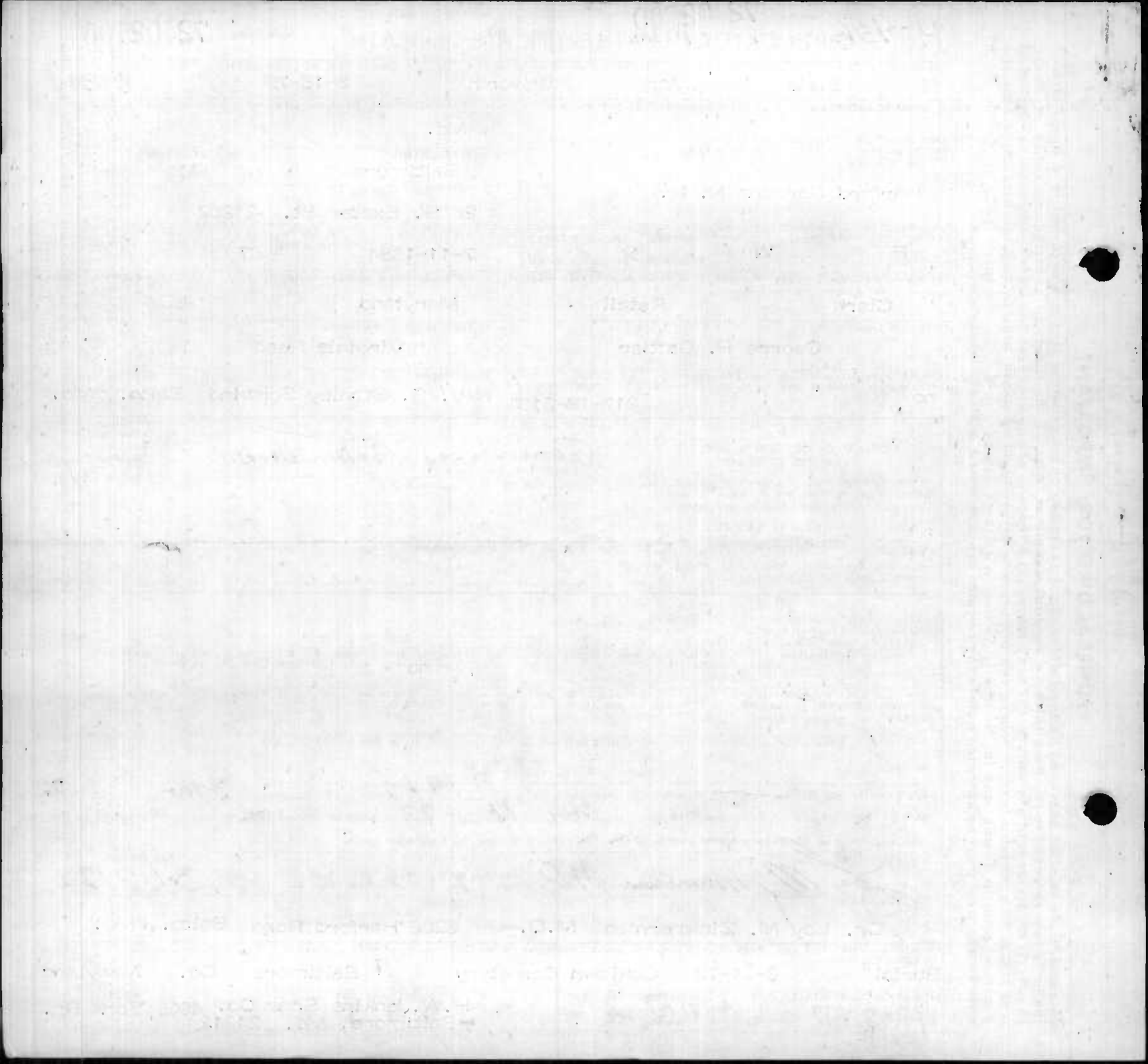
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02699	
B-416 72 02699				CERTIFICATE OF DEATH	
BIRTH NO. 917/90		1. NAME OF DECEASED (Type or Print) Ebbie Blueford aka Blueford		2. DATE AND HOUR OF DEATH 3/12/72 @ 10 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 3458 Spellman Rd. 2562			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) George Washington Nursing Home 607 Pennsylvania Ave		C. CITY OR TOWN MD		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/7/90		9. AGE (in years last birthday) 82 yrs.		If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgetown S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Julius Pineo		14. MOTHER'S MAIDEN NAME Unknown / Susan McFall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 812-55-6152		17. INFORMANT Mrs Zelena Harley 809 N. Brice St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 5-71.0		CAUSE OF DEATH CIRRHOSIS OF LIVER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSION		YRS.	
		(B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC ALCOHOLISM		YRS.	
		(C) 24RS.		2 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). INTESTINAL TUBERCULOSIS					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from FEB 11 - 19 72 to MARCH 12 19 72 that (1) (we) last saw the deceased alive on MARCH 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Richard Tyson, M.D.		23B. DATE SIGNED 3-13-72		23C. ADDRESS 936 W. North Avenue Baltimore, Maryland 21217	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAR 17 1972		25B. NAME OF REGISTRAR Robert E. Felt, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Run		25D. ADDRESS 2222 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

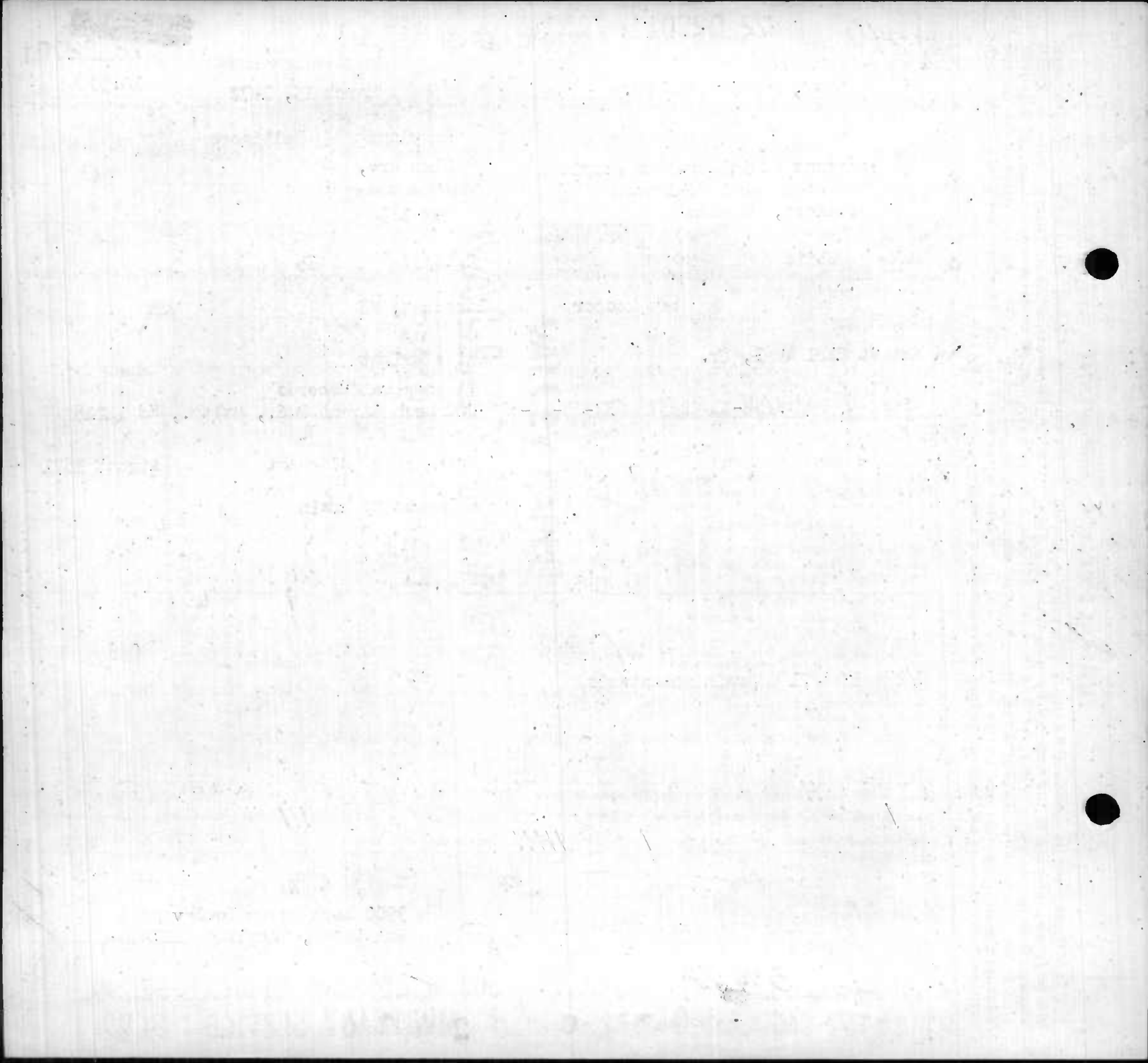
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02700	
<div style="display: flex; justify-content: space-between;"> A-426 72 02700 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Elsie Mae Ailsworth		3-16-72 8:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Harford Gardens N. H.			Md.		
5. SEX		6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-11-1884	87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		Retail		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George P. Gettier			Virginia Read		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		A 217-16-3131		Rev. G. Stanley Schwind Balto., Md.	
18. I			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			Generalized Arteriosclerosis		Several years
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1969 to Mar. 1972, that (I) (we) last saw the deceased alive on Mar. 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Loy M. Zimmerman M.D.				3/17/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Loy M. Zimmerman M.D.				3202 Harford Road Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		3-20-72		Oaklawn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 17 1972		M. W. Jenkins		M. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

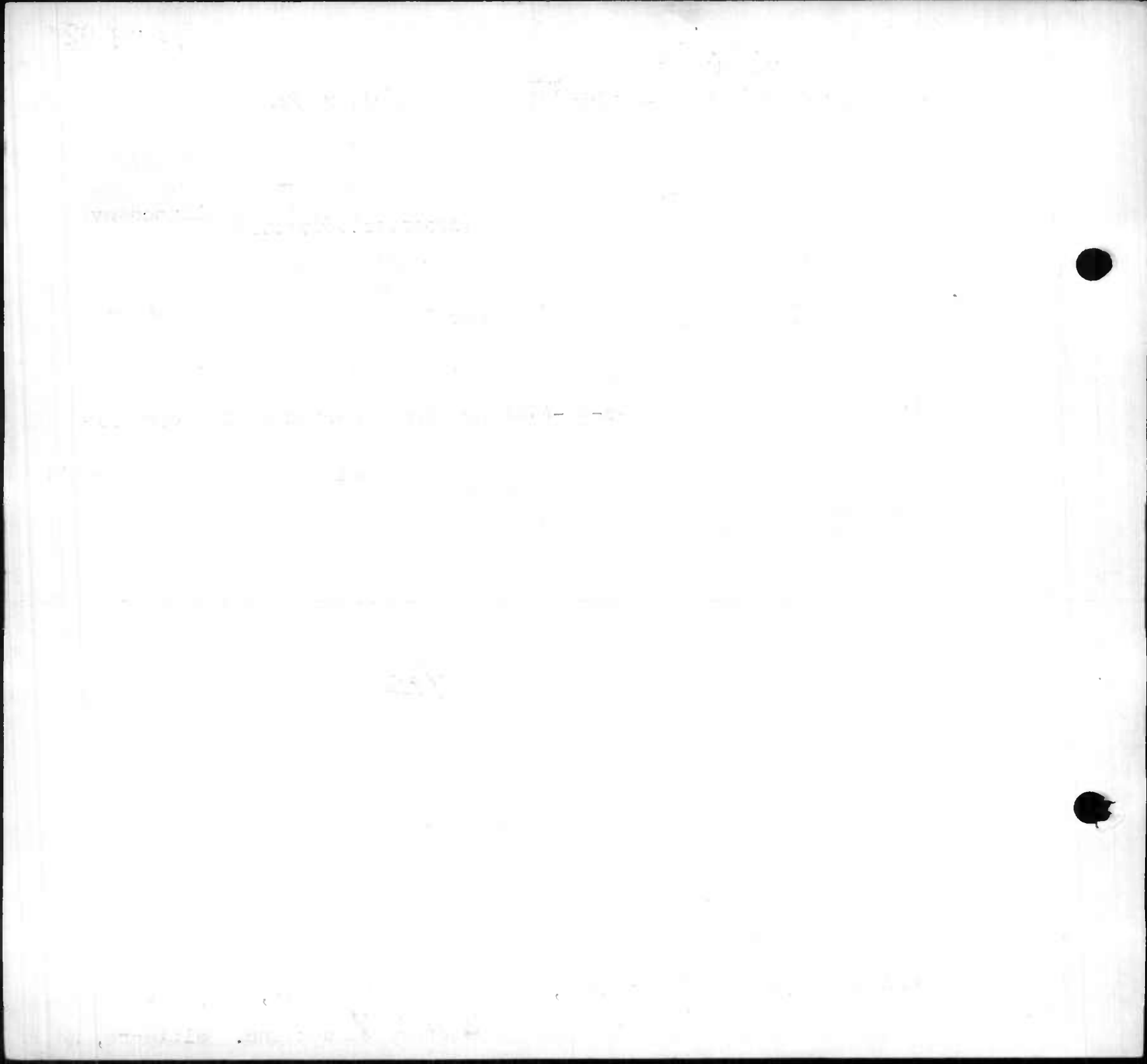
BIRTH NO. A-140		72 02701		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02701	
1. NAME OF DECEASED (Type or Print) ABEL, ERNEST PAUL JR.				2. DATE AND HOUR OF DEATH March 15, 1972 10:30 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION: Veterans Administration Hospital 3900 Loch Raben Boulevard Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Glen Arm, D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 133					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/12/37		9. AGE (In years last birthday) 35		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bee keeper				10B. KIND OF BUSINESS OR INDUSTRY bee keeper				11. BIRTHPLACE (State or foreign country) Claremont, NH	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Ernest Paul Abel, Sr.					
14. MOTHER'S MAIDEN NAME Alice Wright				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/15/54-11/22/57					
16. SOCIAL SECURITY NO. 033-26-53-12				17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic malignant melanoma to brain				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH August 1971					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic malignant melanoma to brain					
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
19A. DATE OF OPERATION 9/2 & 12/7/71				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain metastasis		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that 11 (this hospital) attended the deceased from MARCH 14 19 72 to MARCH 15 19 72 , that 11 (we) last saw the deceased alive on MARCH 15 19 72 and that in 11/11 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) (did) view the body after death.									
23A. SIGNATURE JUAN VORA				23B. DATE SIGNED 3/15/72				23C. PHYSICIAN'S NAME (Type) JUAN VORA MD	
23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218				24A. BURIAL CREMATION, REMOVAL (Specify) 3-16-72					
24B. DATE 3-16-72				24C. NAME OF CEMETERY or CREMATION JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOLD					
24D. NAME OF CEMETERY or CREMATION JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOLD				25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972					
25B. NAME OF REGISTRAR John E. Kelly				25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOLD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 02702</u>	
BIRTH NO. <u>S-530</u>				DECEASED <u>72 02702</u>			
1. NAME OF DECEASED (Type or Print) <u>SENNOT-ELIZABETH</u>				2. DATE AND HOUR OF DEATH <u>3/17/72</u> <u>7 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME AND HOSPITAL</u>				A. STATE <u>USA</u>		B. COUNTY <u>102</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>335 South Ellwood Ave</u>			
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-7-89</u>	
				9. AGE (In years last birthday) <u>82</u>		10. If Under 1 Tr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>CHARLES - Bargerding</u>				14. MOTHER'S MAIDEN NAME <u>KATHRYN Schuler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-09-4124</u>		17. INFORMANT ADDRESS <u>Mrs. Grace Martin 7232 River Drive Rd</u>	
18. <u>410.7 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <u>possible MI</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <u>ASHD, old age</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>3-11-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Good</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-11-1972</u> to <u>3-17-1972</u> that (I) (we) last saw the deceased alive on <u>6:30 AM 3-17-1972</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Reza Sajadi</u> M.D.				23B. DATE SIGNED <u>3-18-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>REZA-SAJADI-MD</u>				23D. ADDRESS <u>CHURCH HOME & HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/20/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Baltimore, Md</u>	



H-540

72 02703

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02703

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATHERINE HAMMEL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3012 Northway Drive		3. DATE PRONOUNCED DEAD Month Day Year Hour March 15, 1972 9:12 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2735			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH May, 4, 1918		10. AGE (In years lost birthday) 53 52x	E. STREET AND NUMBER 3012 Northway Drive
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Albert Hammel
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ins. Under writer		14B. KIND OF BUSINESS OR INDUSTRY U.S.F&G	15. MOTHER'S MAIDEN NAME Anna Deitz
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-12-7685	18. INFORMANT Mr Arthur A Hanson
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E93-3X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Basement	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-14 or 3-15 1972 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Hanged self		21. AUTOPSY? (Yes or No) No	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 15, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/72	
24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. [illegible]	
25C. FUNERAL DIRECTOR Leonard J. [illegible]		25D. ADDRESS 000 [illegible]	

35-1210

10-10-55

Albert Thomas

J. S. A.

Received

Anna Weiss

1st. Under writer J. S. A.

10-10-55

to

WALTER HILL
FOR

Belmont, New York

10-10-55

10-10-55

10-10-55

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02704
G-640 72 02704 BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Harry E. Gorrell		2. DATE AND HOUR OF DEATH 3/15/72		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3000 Fleetwood Ave. 00		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Talbot 7000 C. CITY OR TOWN St. Michaels D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Chew Ave.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1904	9. AGE (In years last birthday) 67 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Secretary-Treasurer Savings & Loan		10B. KIND OF BUSINESS OR INDUSTRY Savings & Loan		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gorrell		
14. MOTHER'S MAIDEN NAME -		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 212-01-4821		17. INFORMANT ADDRESS Mrs. Alverdia Gorrell same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (B) Coronary insufficiency (C) atherosclerosis years years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from February 1971 to 15 March 1972 , that (I) (we) last saw the deceased alive on February 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Donald E. Fisher M.D.		23B. DATE SIGNED 16 March 1972		23C. PHYSICIAN'S NAME (Type) Donald E. Fisher MD
23D. ADDRESS St. Michaels, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3/18/72		24C. NAME OF CEMETERY or CREMATORY Lorraine		
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		
25B. NAME OF REGISTRAR James E. Fisher, Jr.		25C. FUNERAL DIRECTOR ADDRESS Leopold D. Rock Inc. Balto. Md.		

Received of

and have been paid to the

of the

of the

of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02705
BIRTH NO. V-536		72 02705 CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH March 17, 1972
1. NAME OF DECEASED (Type or Print) IDA Ventura		2. DATE AND HOUR OF DEATH March 17, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1902 Woodbourne Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2758 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1902 Woodbourne		
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1895	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Libertini		
14. MOTHER'S MAIDEN NAME Dorothy Restivo		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 		17. INFORMANT Mr Joseph Ventura 126 E Lake Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 201X I Hodgkins Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Yrs		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 	20A. AUTOPSY? (Yes or No) 	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the physician) attended the deceased from November 19 68 to 16 March 19 72 , that (I) last saw the deceased alive on 16 March 19 72 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.				
23A. SIGNATURE Dr. Dixon Hills		23B. DATE SIGNED 17 March 72		23C. PHYSICIAN'S NAME (Type) Dr. Dixon Hills
23D. ADDRESS 3501 St. Paul St., Baltimore, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3/20/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Leonard J. Buck, Inc. - Balto, Md.		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc. - Balto, Md.

517-10-47

1

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-000 72 02706		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02706	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SHAW, AUGUSTA</u>		2. DATE AND HOUR OF DEATH <u>3/15/72</u> <u>8:50</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		Maryland		C. CITY OR TOWN <u>Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>4940 Eastern Avenue</u> <u>21224</u>	
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-87</u>	9. AGE (in years last birthday) <u>81</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hswf.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>John G. Stricker</u>		14. MOTHER'S MAIDEN NAME <u>Catherine - - - -</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH RECORDS:</u> <u>4940 Eastern Avenue 21224</u>	
18. <u>153.8</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>WREST</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Ch of COLON & Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>Signs</u>	
		(C) <u>Anemia</u>		<u>340.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Rheumatoid Arthritis</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8:30. 69</u> 19 <u>72</u> to <u>3/15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Karen O'Neill</u>		23B. DATE SIGNED <u>3/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Karen O'Neill, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>20 Mar 72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u>		25B. NAME OF REGISTRAR <u>Rich E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Rich E. Fisher</u>	
		25D. LOCATION <u>Balto. Co., Md.</u>		ADDRESS <u>Rich Funeral Home, Balto., Md. 21206</u>	

3134 Foster Ave.

CHARTERED AIRCRAFT
IN WEST

Plot of Colon & West Coast

Area

Remained at West

2/12

2/12 2:30 PM

Karen Jones

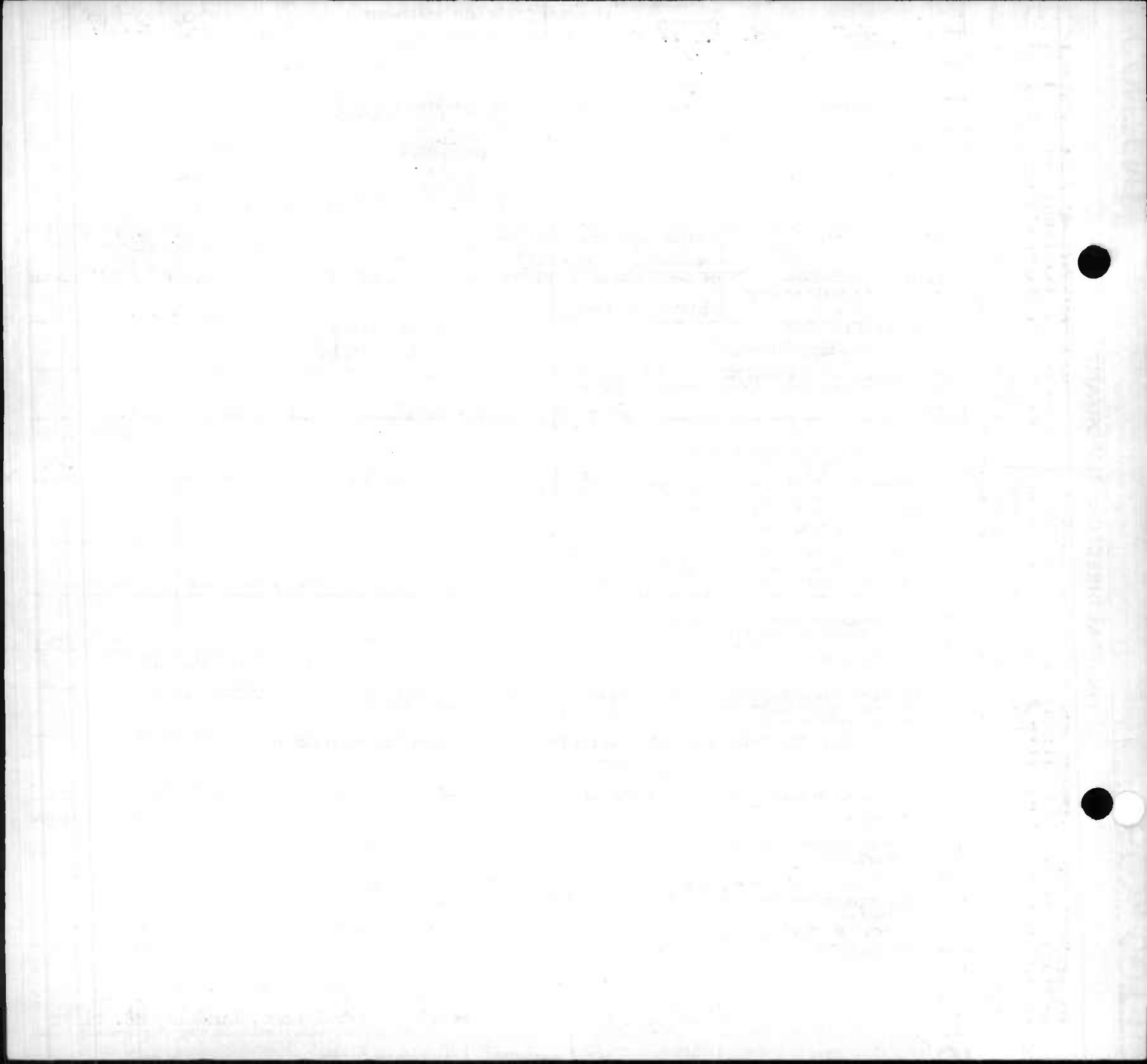
2/12/15

8:14

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02707	
<div style="font-size: 2em; font-weight: bold;">G-655</div> <div style="font-size: 1.5em; font-weight: bold;">72 02707</div>		CERTIFICATE OF DEATH			
BIRTH NO. 6-655		1. NAME OF DECEASED (Type or Print) JAMES V. GORMAN.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 3-16-72 10:45 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE. 42 INC		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2788			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3535 HAYWARD AVE			
5. SEX M.	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1896	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10B. KIND OF BUSINESS OR INDUSTRY church office		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Gorman		14. MOTHER'S MAIDEN NAME Mary Hughes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-6970		17. INFORMANT ADDRESS Mrs. Mabel Gorman, 3535 Hayward Ave. 21215	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH C.V.A. BILATERAL PNEUMONIA METABOLIC ACIDOSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) D.S.C.V.A. - C.O.L.D. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-5 DAYS 25 YEARS	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-16-72 to 3-16-72 that (I) (we) last saw the deceased alive on 3-16-72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE GUTIERREZ				23B. DATE SIGNED 3-16-72	
23C. PHYSICIAN'S NAME (Type) FELIX GUTIERREZ				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 20 Mar 72		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21213		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972			
25B. NAME OF REGISTRAR R. B. S. S. S.		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home, Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		72 02708		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02708	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Ruth M. Causey			
2. DATE AND HOUR OF DEATH March 17, 1972				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 237 1/2 South Stricker Street			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17, 1916	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Harry L. Stevens			
14. MOTHER'S MAIDEN NAME Carrie May Moss				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 247-28-8376				17. INFORMANT Wilbur M. Stevens 21223 Schroeder St			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 25071 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 3/15/72 to 3/17/72 1972 and that (I) (we) last saw the deceased alive on 3/15/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] 23B. DATE SIGNED MAR 18 1972 23C. PHYSICIAN'S NAME (Type) VASH 23D. ADDRESS 206 S. Gilmore St. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 03/21/72 24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park 24D. LOCATION (City, town, or county) (State) Howard County, Maryland 25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972 25B. NAME OF REGISTRAR [Signature] 25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Streets 21223							

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

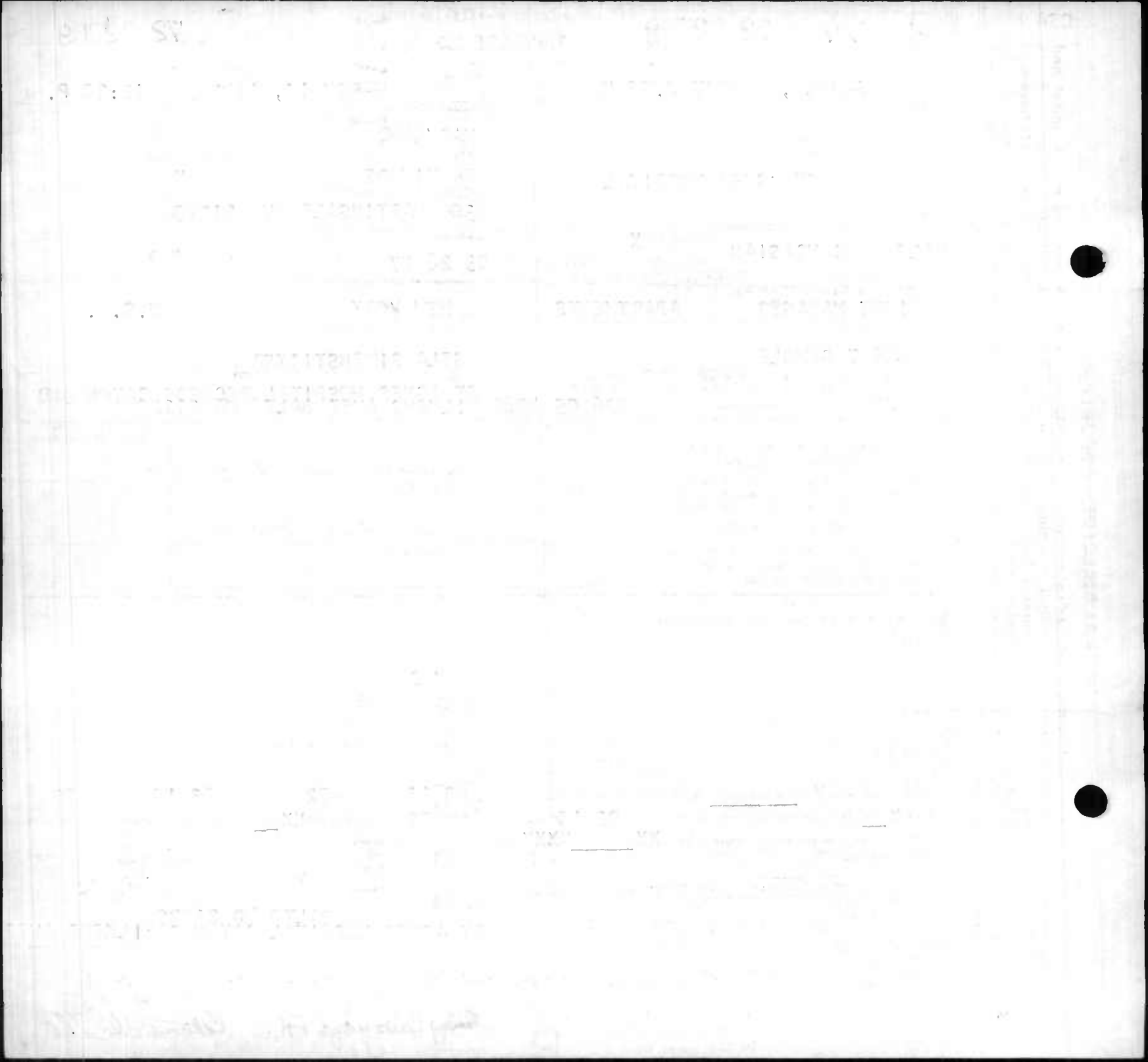
1944-1945

1944-1945

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CSA

G-514 72 02709		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02709	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GAMBLE, ROBERT JOSEPH		2. DATE AND HOUR OF DEATH MARCH 15, 1972 12:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2541		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		E. STREET AND NUMBER 306 MARTINGALE AVE 21229			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03 28 07	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIGHT MANAGER		10B. KIND OF BUSINESS OR INDUSTRY APARTMENTS		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT GAMBLE		14. MOTHER'S MAIDEN NAME GELA SIDENSTICKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 096 05 4989		17. INFORMANT ST AGNES HOSPITAL RECORDS CATON AND WILKENS AVES BALTO MD 21229	
18. 39491 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary heart failure</i> (B) <i>severe mitral stenosis</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 03 13 1972 to 03 15 1972 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 03 15 1972 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Eitatsu Henzan</i>		23B. DATE SIGNED 3/15/72		23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Burial Park	
24D. LOCATION Elkridge Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Haley, Catherine FH.		25D. ADDRESS Columbia Md			



C-623

72 02710

BALTIMORE CITY HEALTH DEPARTMENT

72 02710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) J. Frederick Christian		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 10 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 10 72 1:50 p.m.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2636	
9. DATE OF BIRTH 4-20-07		10. AGE (In years last birthday) 64	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME George F. Christian		14. STREET AND NUMBER 1407 S. Bonsal Street	
15. MOTHER'S MAIDEN NAME Martha Lewis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
17. SOCIAL SECURITY NO. 212-07-3875		18. INFORMANT Friend: 1407 S. Bonsal Street Mrs. Anne Blackman Balto. Md. 21224	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive + Arteriosclerotic Cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22E. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. DATE SIGNED 3/11/72 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-15-72	
24C. NAME of CEMETERY or CREMATORY Mt. Carmel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR 7922 Wise Ave. Dundalk, Md.		ADDRESS	

15 5710

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-612		72 02711		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02711	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) ARBAUGH, GUY. E.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 3-15-72 10:30 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		1307	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3962 FALLS ROAD			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-12-96		9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY TEXTILE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ARBAUGH JACOB				14. MOTHER'S MAIDEN NAME ELLA UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1ST W.W.		16. SOCIAL SECURITY NO. 215-07-2471A		17. INFORMANT ADDRESS ELSIE P. ARBAUGH 3962 FALLS ROAD			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA of PROSTATE & LUNG METASTASIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHF - UTI				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-6-72 to 3-15-72 that (I) (we) last saw the deceased alive on 3-15-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Julio A. Dejo</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-15-72	
23C. PHYSICIAN'S NAME (Type) JULIO A. DEJO M.D.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-18-72		24C. NAME of CEMETERY or CREMATORY DRUID RIDGE		24D. LOCATION (City, town, or county) (State) PIKESVILLE MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Paul E. Anderson		25C. FUNERAL DIRECTOR 3617 Chestnut Ave.		ADDRESS	

TEXTILE

1st W.W.

121

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 7-610				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02712	
1. NAME OF DECEASED (Type or Print) Adeline M. Froeb				2. DATE AND HOUR OF DEATH March 16, 1972					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1903					
				C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 1817 Wilkens Avenue					
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-25-1909		9. AGE (In years last birthday) 62		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Augustus Rhoades				14. MOTHER'S MAIDEN NAME Jennie Brost	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-07-9578B		17. INFORMANT Mr. Gustav Froeb, 1817 Wilkens Ave. 21223			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Insufficiency				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular disease					
				(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus					
				(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 14 1972 to March 16 1972 , that (I) (we) last saw the deceased alive on March 14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Isadore Sborofsky MD				23B. DATE SIGNED 3/16/72				23C. PHYSICIAN'S NAME (Type) Isadore Sborofsky	
23D. ADDRESS 601 N. Monroe Street, Baltimore, Md.				23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-20-1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Wilkens Ave., Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972				25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02713

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND JOSEPH GAYLEARD SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour March 18, 1972 12:49 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2553		6. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/25/1942	10. AGE (In years last birthday) 29	11. BIRTHPLACE (State or foreign country) Balt. Ind.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Gayleard	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		15. MOTHER'S MAIDEN NAME Alvina Brown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 24-38-4148	
18. INFORMANT Anna Shadle		ADDRESS -1926 Maisel St. 21230	
19. CAUSE OF DEATH Multiple gunshot wounds of abdomen		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 3/18/72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 3-18-72 12:35 A.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 400 Block S. Payson Street 2003	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		DATE SIGNED 3/18/72	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 3/21/72	
24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Balt. Ind.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR John J. Grogan, Inc.		ADDRESS 901 Hollins St. Balt. Ind. 21228	

15-513

15-513

WALL PAPER FLOOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-252		72 02714		72 02714	
1. NAME OF DECEASED (Type or Print) Herman McKnight			2. DATE AND HOUR OF DEATH 3/17/72 6:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Gen Hosp. 3001 S. Hanover St Balto., Md. 21230			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2544		
5. SEX M 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 10-7-09 9. AGE (In years lost birthday) 62		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner			11. BIRTHPLACE (State or foreign country) Georgia		
10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Raymond McKnight			14. MOTHER'S MAIDEN NAME Mandy? Brook's		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 285-05-8285		
17. INFORMANT Daughter Rachel Klebe ADDRESS same as above					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial arrhythmia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypoxia - severe			DUE TO OR AS A CONSEQUENCE OF: One year		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD			DUE TO OR AS A CONSEQUENCE OF: 5 years		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 13 Mar 1972 to Mar 17 1972 . that (I) (we) last saw the deceased alive on Mar 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Colvin C. Carter, M.D.			23B. DATE SIGNED 3/17/72		
23C. PHYSICIAN'S NAME (Type) Colvin C. Carter, M.D.			23D. ADDRESS 3001 S. Hanover St. Balto., Md. South Balto. Gen. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/72		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Ac Cully F.H.		25C. FUNERAL DIRECTOR ADDRESS 237 Patapsco Ave. Balto. 21225	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-620		72 02715		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02715	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MARY KATHRYN KRAUCH				March 16, 1972		1:25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital				A. STATE Md.		B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3100 Wyman Parkway				C. CITY OR TOWN Fullerton		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 42 Henry Avenue							
5. SEX F		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/6/49	
				9. AGE (In years last birthday) 23		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10B. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Krauch				14. MOTHER'S MAIDEN NAME Charlotte Dodd			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-50-5799		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, possible sepsis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) (Etiology unknown) DUE TO, OR AS A CONSEQUENCE OF: (C)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Stage IVB Hodgkin's disease Pancytopenia, secondary to chemotherapy						3 yrs. 1 wk.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Mar. 15 1972 to Mar. 16 1972, that (I) (we) lost saw the deceased alive on Mar. 16 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. J. O'Connell, M.D.						23B. DATE SIGNED 3/16/72	
23C. PHYSICIAN'S NAME (Type) Michael J. O'Connell, Surg (R)				23D. ADDRESS US PHS Hospital, Balto, Md. 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/72		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville Balto.. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR J. J. O'Connell		25C. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd. Balto.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02716	
N-220 72 02716		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Negus, Mildred		2. DATE AND HOUR OF DEATH 3/15/72 112¹⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY MONTGOMERY	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION BALTIMORE, MD 21205		C. CITY OR TOWN KENSINGTON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 11107 WEST AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-06
9. AGE (in years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Mass		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Philip NEGUS		14. MOTHER'S MAIDEN NAME SARAH DAVIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 578-46-4147	
17. INFORMANT T.S. MacHale		ADDRESS Rockville, Md 13110 Cleveland Dr	
18. 4-36-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Resp. arrest (B) LCVA DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 mins.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/6 19 72 to 3/15 19 72 that (1) (we) last saw the deceased alive on 3/15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George E. Kurent M.D.		23B. DATE SIGNED 3/15/72	
23C. PHYSICIAN'S NAME (Type) TEROME E. KURENT M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3/17/72	
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		24D. LOCATION (City, town, or county) Suitland Pr. Geo Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert A Pumphrey F. H.	
25C. FUNERAL DIRECTOR 7557 Wisconsin Ave. Bethesda Md			

9

RECEIVED

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		72 02717		BALTIMORE CITY HEALTH DEPARTMENT		72 02717	
BIRTH NO.		72 02717		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) BYRNE, SADIE A				2. DATE AND HOUR OF DEATH 3/14/72 12:15p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING AND CONVALESCENT CENTER 1400 JOHN STREET BALTIMORE, MARYLAND 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 909 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1545 ENSOR STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/82	9. AGE (In years last birthday) 89	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY FACTORY WORK		11. BIRTH PLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN FRANCIS H. O'BRIEN				14. MOTHER'S MAIDEN NAME UNKNOWN BRIDGET REVILLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-56-9251		17. INFORMANT PATIENT'S ADMISSION RECORD FAMILY 4522 N. CHARLES ST.			
18. 4109 4153.8 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTHELMINTIC RESISTANCE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTHRITIS GENERALIZED CA color & body				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: antelmintic resistance		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
(B) DUE TO, OR AS A CONSEQUENCE OF: antelmintic resistance				(C) DUE TO, OR AS A CONSEQUENCE OF: antelmintic resistance		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CA color & body							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/11/68 to 3/14 19 72 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE ALLAN MACHT, M.D.				23B. DATE SIGNED 3/15/72		23C. PHYSICIAN'S NAME (Type) ALLAN MACHT, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-17-1972		24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Baker, M.D.		25C. FUNERAL DIRECTOR Shelton & Dublin		25D. ADDRESS 5444 Belair Rd	

1155 ST

1155 ST

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

1155

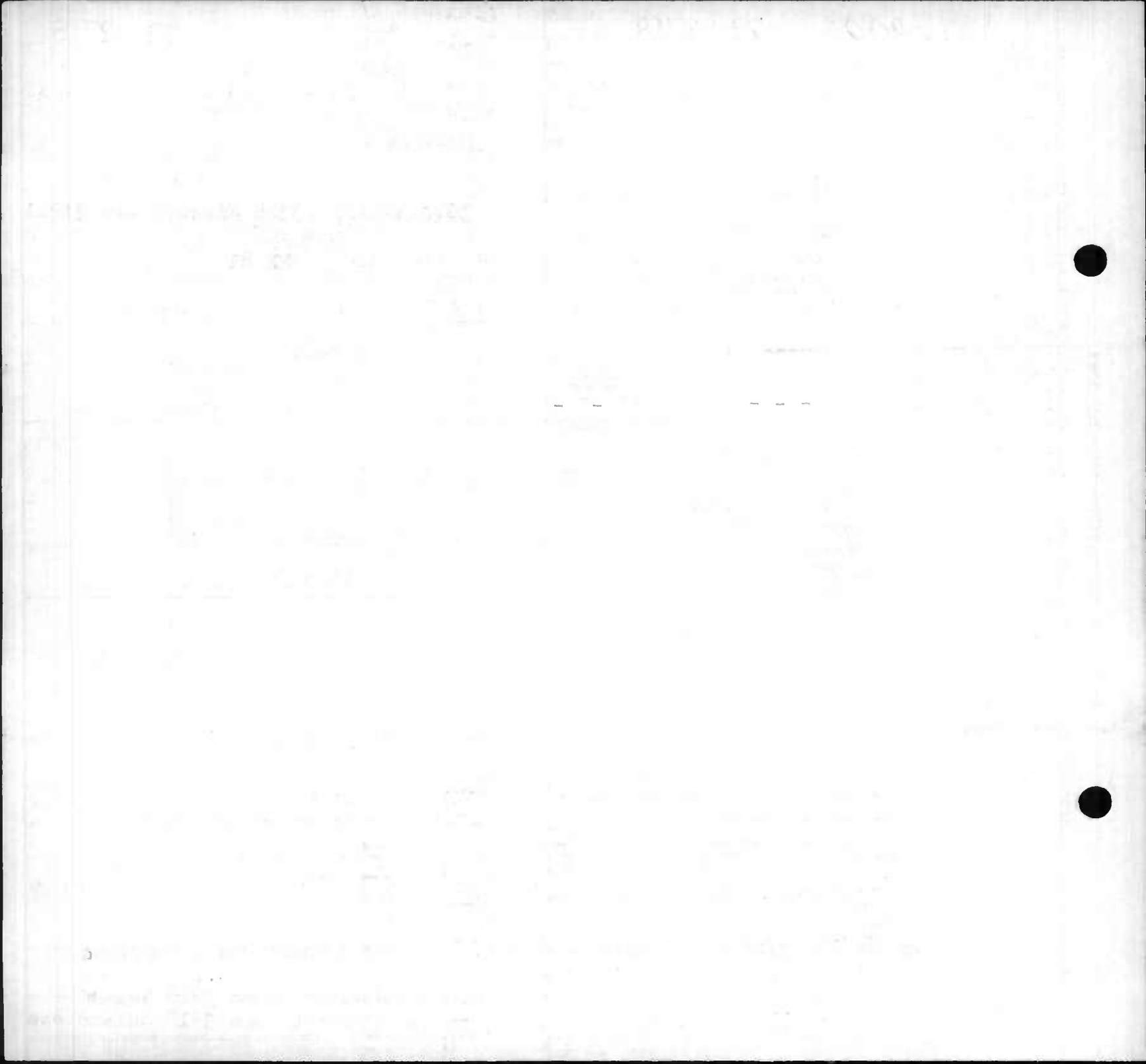
1155

1155

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02718		72 02718	
L-200		72 02718		72 02718	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LAKE FRANCES M.		3/16 / 1972 6 AM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		1306	
+ 4 Union Memorial Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3344 Hickory Ave 21211			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-14-90	9. AGE (in years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Newnan		14. MOTHER'S MAIDEN NAME Martin		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3455		17. INFORMANT Gladys Martin 3344 Hickory Avenue	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic shock (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Edema (C) Chronic C.H.F. H/O M.I.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 03/14 1972 to 03/16 1972 that (I) (we) lost saw the deceased alive on 03/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ghassan Nahas M.D.				23B. DATE SIGNED 03/16 / 1972	
23C. PHYSICIAN'S NAME (Type) Ghassan Nahas		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/72		24C. NAME OF CEMETERY or CREMATORY Sater's Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.		25C. FUNERAL DIRECTOR Donovan Funeral Home 3818 Roland Ave	



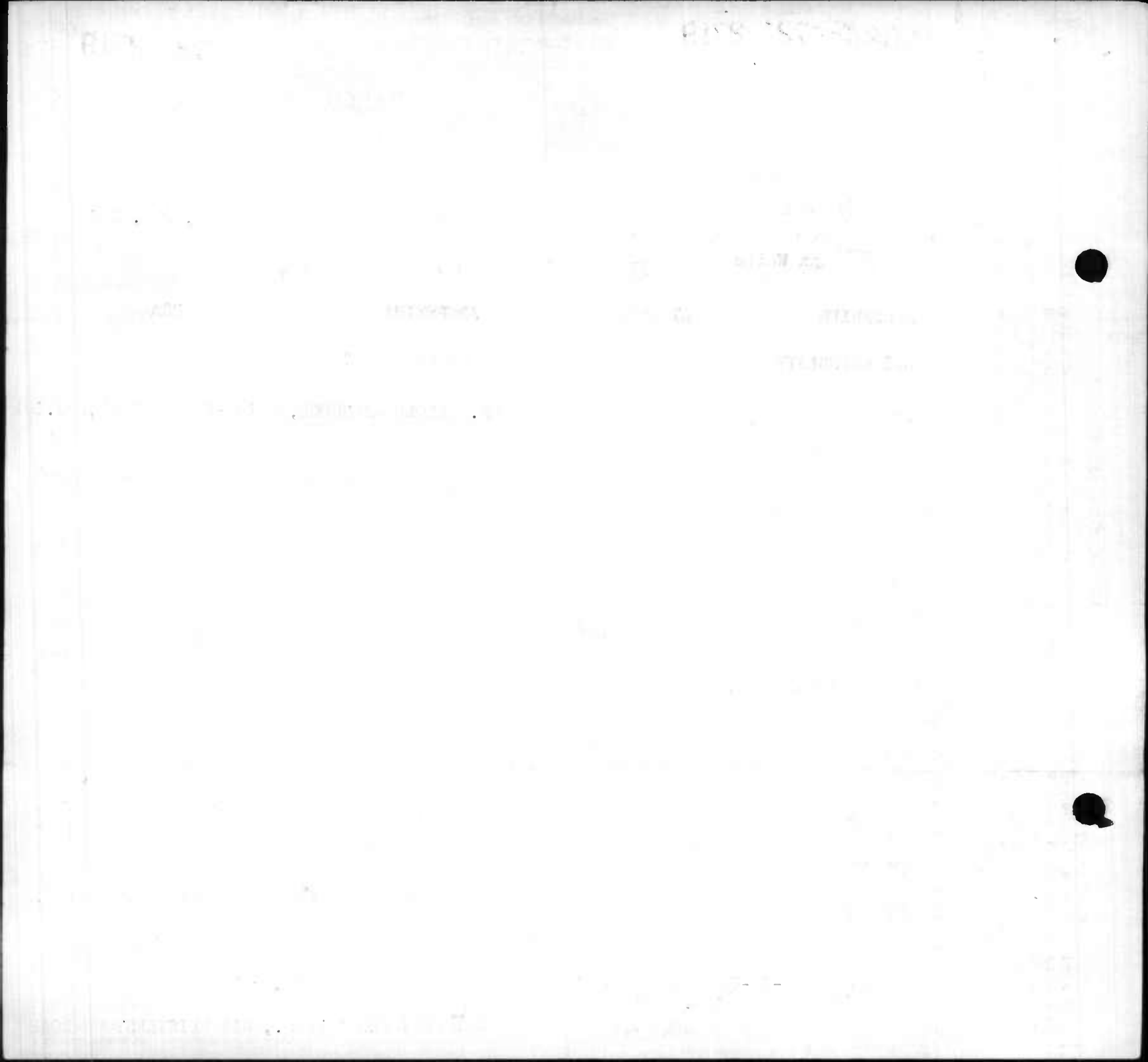
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-622 72 02719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02719

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROSE BARSHOOK		2. DATE AND HOUR OF DEATH MARCH 15th, 1972 2 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2831		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER 6610 VINCENT L2., APT. 201		
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) ARGENTINA	
13. FATHER'S NAME ELI CORNBLATT			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT MR. HAROLD BARSHOOK, 6610 VINCENT LANE, APT. 201
18. 25071 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF: (B) GANGRENE RIGHT LEG DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arthritis, Diabetes Mellitus, Cataracts					
19A. DATE OF OPERATION MARCH 9/1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE RIGHT LEG		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 3 19 72 to MARCH 15 19 72 that (I) (we) lost saw the deceased alive on MARCH 15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mirelman</i>			23B. DATE SIGNED MARCH 15, 1972		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) DANIEL W. MIRELMAN M.D.			23D. ADDRESS SINAI HOSP. OF BALTO.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-16-72		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOI LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02720	
G-362		72 02720			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) IRVING H. GUTHARZ		2. DATE AND HOUR OF DEATH 3/14/72 1 31st P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN PIKEVILLE	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 6816 Timberlane Rd #9			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/11	9. AGE (In years last birthday) 60	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN WHOLESALE BEAUTY SUPPLIES		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK CITY, N.Y.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO. 216-09-9769		17. INFORMANT MRS. SYLVIA GUTHARZ, 6816 TIMBERLANE RD. #9	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/10/71 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism (B) Acute Coronary Thrombosis (C) Aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. 12 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic obstructive lung disease			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 19 3/14/72 to 3/14/72 19 3/14/72 that (I) (we) last saw the deceased alive on 3/14/72 19 3/14/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph J. Kearns		23B. DATE SIGNED 3/14/72		23C. PHYSICIAN'S NAME (Type) J. J. KEARNS MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-16-72		24C. NAME OF CEMETERY OR CREMATORY QIEB SHALOM	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Zuber		25C. FUNERAL DIRECTOR SOE LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02721	
C-500		72 02721		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JACOB COHEN		MARCH 15, 1972 3 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE		
			B. COUNTY		
MT. SINAI NURSING HOME			MARYLAND		2798
			C. CITY OR TOWN		
			BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			4613 PARK HEIGHTS AVENUE #21215		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG. 10, 1885	86	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
GROCER		SELF EMPLOYED		RUSSIA	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
HARRY COHEN			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
NO			218-32-3340		MR. WILLIAM COHEN, 3806 GLENGYLE AVENUE #21215
18. CAUSE OF DEATH			ADDRESS		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			CUA		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			ASCVD		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>68</u> to <u>present</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Leon G. Sheer M.D.</i>				3/15/72	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
LEON G. SHEER			6715 PARK HEIGHTS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3-16-72		KNESSETH ISRAEL ANSHE KOLK	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 20 1972				SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

3624 OAKMONT AVE. 21215

Adm. 7/69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02722
B-450 72 02722		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ISADORE M. BLOOM		2. DATE AND HOUR OF DEATH MARCH 16, 1972 9:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BELVEDERE NURSING HOME		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 4-01 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8 CHARLES PLAZA, APT. 501 #21201		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 4, 1898	9. AGE (In years last birthday) 72 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME SAMUEL BLOOM		
14. MOTHER'S MAIDEN NAME TILLIE ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 218-03-2149		17. INFORMANT MRS. IDA M. BLOOM, 8 CHARLES PLAZA, APT. 501		
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Lungs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II Pathological Fracture left tibia 1/72		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/31 1976 to 3/16 1972 , that (I) (we) last saw the deceased alive on 3/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Israel Zinberg		23B. DATE SIGNED 3/16/72		23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-16-72		24C. NAME OF CEMETERY or CREMATORY AIT ZN CHAM
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. ADDRESS 4000 W. NORTHERN PARKWAY		
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Zinberg		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

1/1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02723		72 02723	
G-431				72 02723		72 02723	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) GOLDBERG, MARY		2. DATE AND HOUR OF DEATH 3-15-72 6:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2730			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp. of Baltimore, Inc.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3018 FALLSTAFF MANOR COURT			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/15/82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HIRSCH ITZKOVITZ				14. MOTHER'S MAIDEN NAME RACHAEL ITZKOVITZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-5951		17. INFORMANT MRS. ESTHER SKLAR, 2902 MARNAT ROAD #21209			
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anteromedial basilar dis. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sev. yrs.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-27 19 72 to 3-15 19 72 that (I) (we) last saw the deceased alive on 3-15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Veneranda C. Gerasimio				23B. DATE SIGNED 3/15/72		23C. PHYSICIAN'S NAME (Type) Veneranda C. Gerasimio	
23D. ADDRESS Sinai Hosp. of Baltimore, Inc.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-16-72		24C. NAME OF CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL,		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

255 55

255 55

255 55

255 55

255 55

255 55

255 55

255 55

255 55

255 55

255 55

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

144 24
CREW, JOHN

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
C-600		72 02724		72 02724	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOHN CREW		MARCH 15, 1972 2.10A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2611 E MADISON ST.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 05/05/12	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Guard		Pinkerton Security Agency Md.		U.S.A.	
13. FATHER'S NAME HARRY CREW		14. MOTHER'S MAIDEN NAME MARY CECILIA TAYLOR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service yes WW II		16. SOCIAL SECURITY NO. 163-03-9290		17. INFORMANT John Crew IV (son) 96 Rumelia Circle	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic Carcinoma</i> (B) <i>Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Composite Resection Jaw/Neck		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/21 19 72 to 3/15 19 72 that (1) (we) lost saw the deceased alive on 3/15 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James Heroy M.D.</i>				23B. DATE SIGNED 3/15/72	
23C. PHYSICIAN'S NAME (Type) JAMES HEROY, M. D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/72		24C. NAME OF CEMETERY or CREMATORY Still Pond Cemetery	
				24D. LOCATION (City, town, or county) (State) Still Pond, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Schimmek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21215	

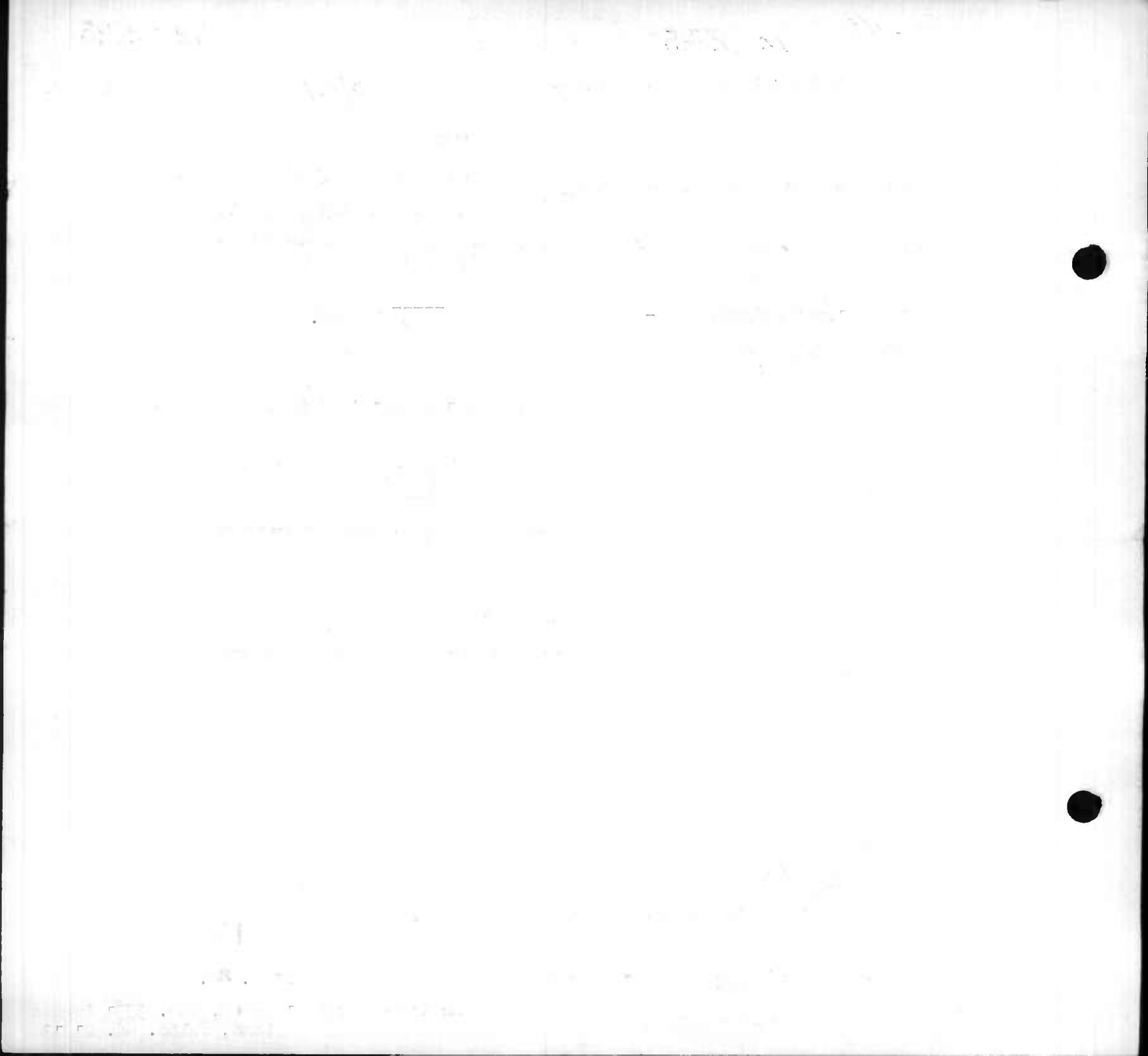
105



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

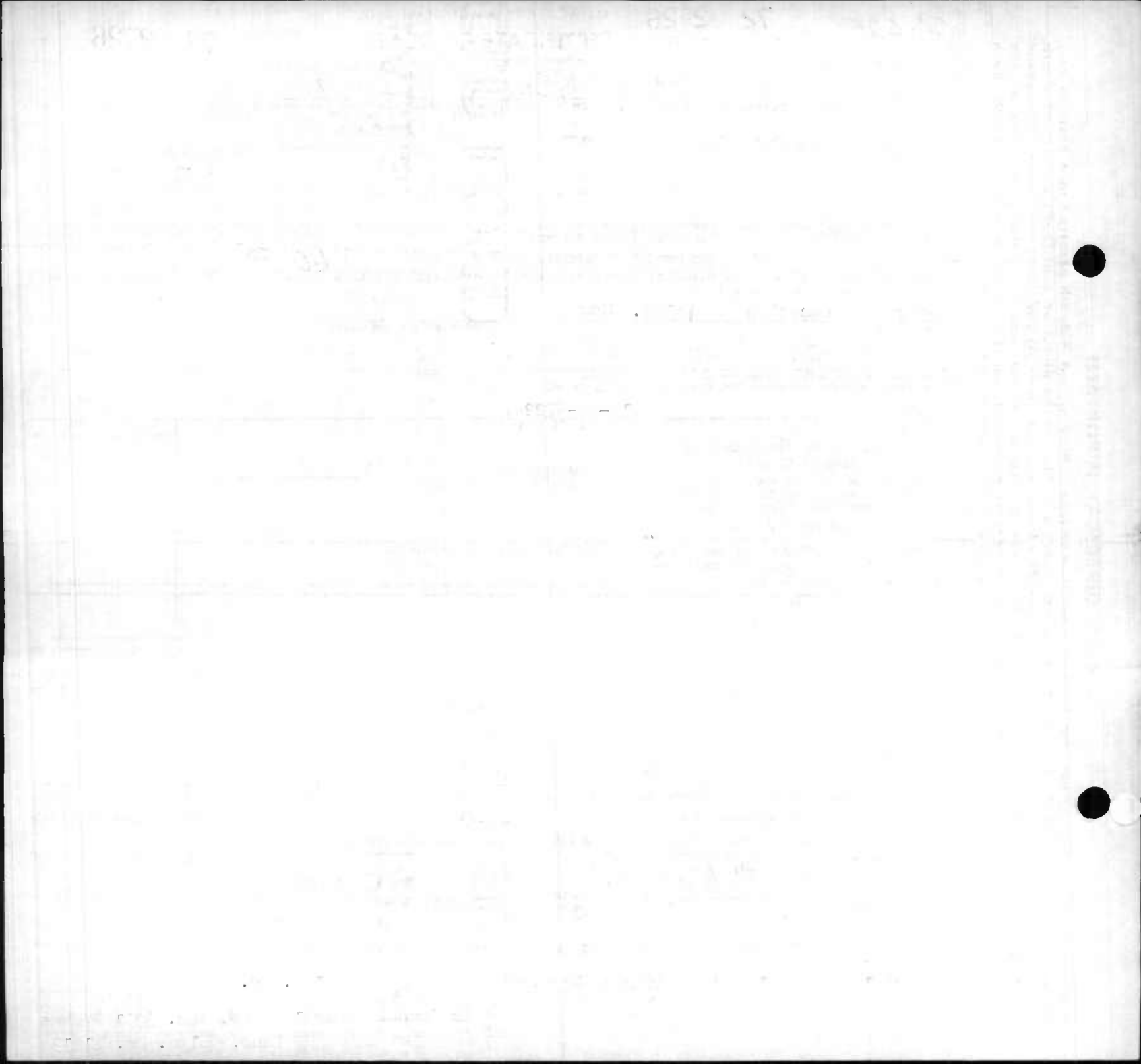
BIRTH NO. S-420		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02725	
1. NAME OF DECEASED (Type or Print) SZELIGA HENRY			2. DATE AND HOUR OF DEATH 3/12/72 1.25 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL 35			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 701		
5. SEX M			6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Sealer (retired)			10B. KIND OF BUSINESS OR INDUSTRY -		8. DATE OF BIRTH 10/17/98
13. FATHER'S NAME John Szeliga			14. MOTHER'S MAIDEN NAME -		9. AGE (in years last birthday) 73
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 217-07-4466		11. BIRTHPLACE (State or foreign country) Md.
17. INFORMANT Evelyn Szeligia (wife)			ADDRESS same as above		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic Shock ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic Shock (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Atherosclerotic disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. P. GIRDHAR M.D.			23B. DATE SIGNED 3/12/72		23C. PHYSICIAN'S NAME (Type) S. P. GIRDHAR M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 3/16/72		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery
24D. LOCATION Balto. Md.			25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		
25B. NAME OF REGISTRAR Richard E. Fisher, M.D.			25C. FUNERAL DIRECTOR Schmunek Funeral Homes, Inc.		
ADDRESS 3331 Brehms Lane, Balto. Md. 21213			ADDRESS 3331 Brehms Lane, Balto. Md. 21213		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

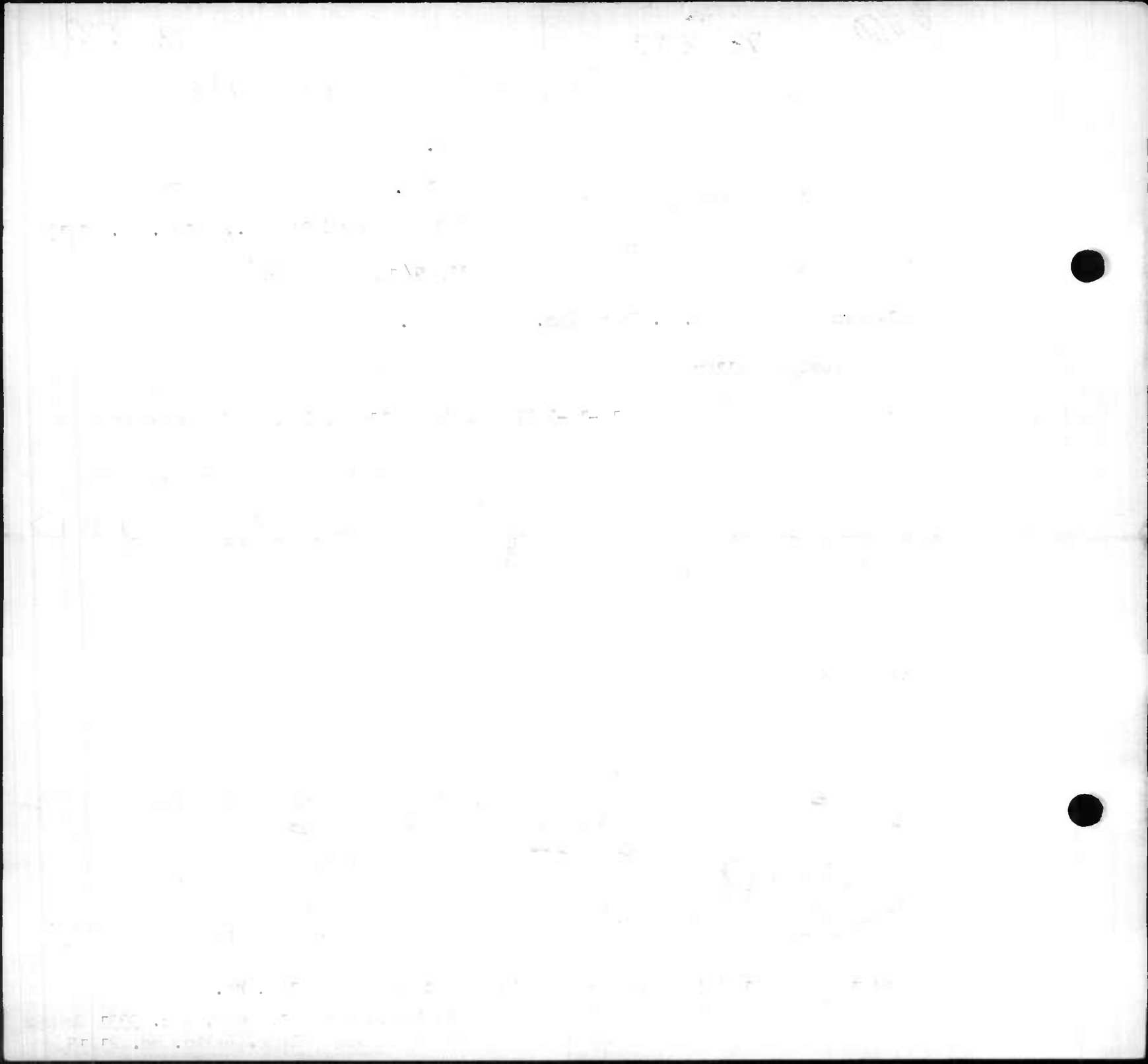
G-625		72 02726		BIRTH NO.		REG. NO. 72 02726	
1. NAME OF DECEASED (Type or Print) WILLIAM GRISINGER, SR.				2. DATE AND HOUR OF DEATH 3-12-72 11559. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44				A. STATE MARYLAND		B. COUNTY 841	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3237 LAWNVIEW AVE 21213							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/11	9. AGE (In years last birthday) 60 59	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Board of Education		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME SAMUEL LINDWOOD CRISINGER				14. MOTHER'S MAIDEN NAME EDNA HALLOWAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-22-5722		17. INFORMANT EVELYN GRISINGER		ADDRESS SAME	
18. 427.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-12 19 72 to 3-12 19 72 that (I) (we) last saw the deceased alive on 3-12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Juan M. Calderon				23B. DATE SIGNED 3-12-72			
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.				23D. ADDRESS UMH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/17/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Reese, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-460		72 02727		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02727	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Lawrence Phaller</u>				2. DATE AND HOUR OF DEATH <u>3/13/72 1:40 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2633</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hosp</u> <u>48</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3528 Chesterfield Ave., Balto. Md. 21213</u>							
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/29/14</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>R. S. Stern Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph Phaller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Zink</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-10-3637</u>		17. INFORMANT <u>Ruth Phaller (wife)</u>		ADDRESS <u>same as above</u>	
18. <u>157.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMATOSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pancreatic Ca.</u> <u>2 MOS</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>74</u> (this hospital) attended the deceased from <u>3/11</u> 19 <u>72</u> to <u>3/13</u> 19 <u>72</u> that <u>4</u> (we) last saw the deceased alive on <u>3/13</u> 19 <u>72</u> and that <u>in my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.							
23A. SIGNATURE <u>Joan M. Pardo</u>				23B. DATE SIGNED <u>3/13/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Joan M. Pardo</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/16/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u>		25B. NAME OF REGISTRAR <u>John E. Baker, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-635		72 02728		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02728	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Norton, Harold E</i>				2. DATE AND HOUR OF DEATH <i>3-7-72 11:55 A.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Harward</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>North Charles Gen Hosp</i> <i>49 2724 N. Charles St</i>						C. CITY OR TOWN <i>Laurel</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>2501 Scaggs Mill Rd</i>									
5. SEX <i>M</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/11/13</i>	9. AGE (In years last birthday) <i>58</i>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>State Roads Commission</i>		11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jim Norton</i>				14. MOTHER'S MAIDEN NAME <i>Emma Camran</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>417051016</i>		17. INFORMANT <i>Hosp. chart</i>			
18. <i>536.1 I</i> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6-8 hrs</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory failure</i>					
ANTECEDENT CAUSES				(B) <i>Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>Gastric Dilatation & Septicemia</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>12-23-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Barium Enema Ex.</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>2-11</i> 19 <i>72</i> to <i>3-7</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>3-7</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Jose G. Ortiz M.D.</i>				23B. DATE SIGNED <i>3/7/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Jose G. Ortiz M.D.</i>			
23D. ADDRESS <i>Laurel, Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/11/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Evolution Church Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Laurel, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 20 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Laurel, Md.</i>					

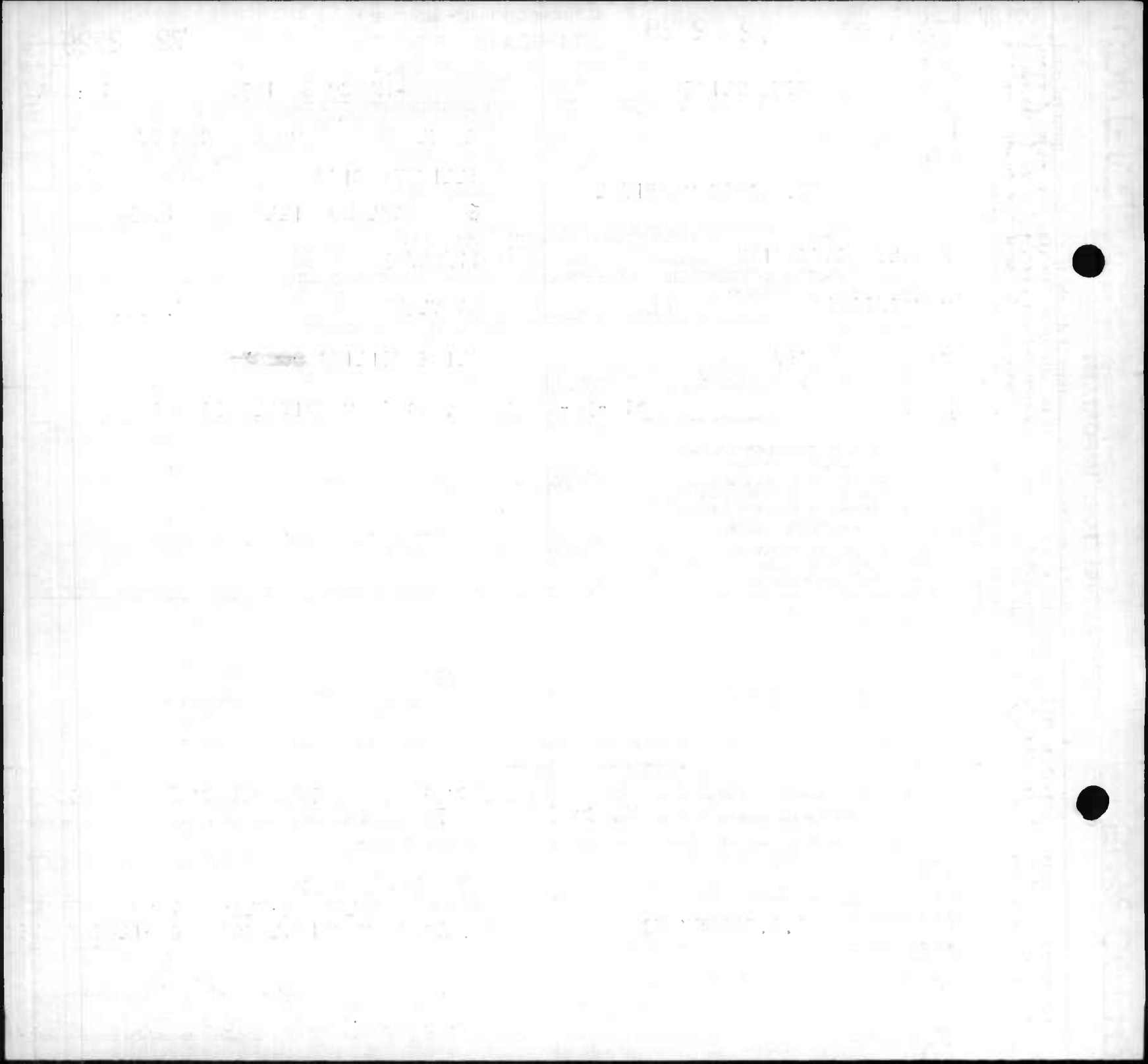
2578 88

2578 88

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

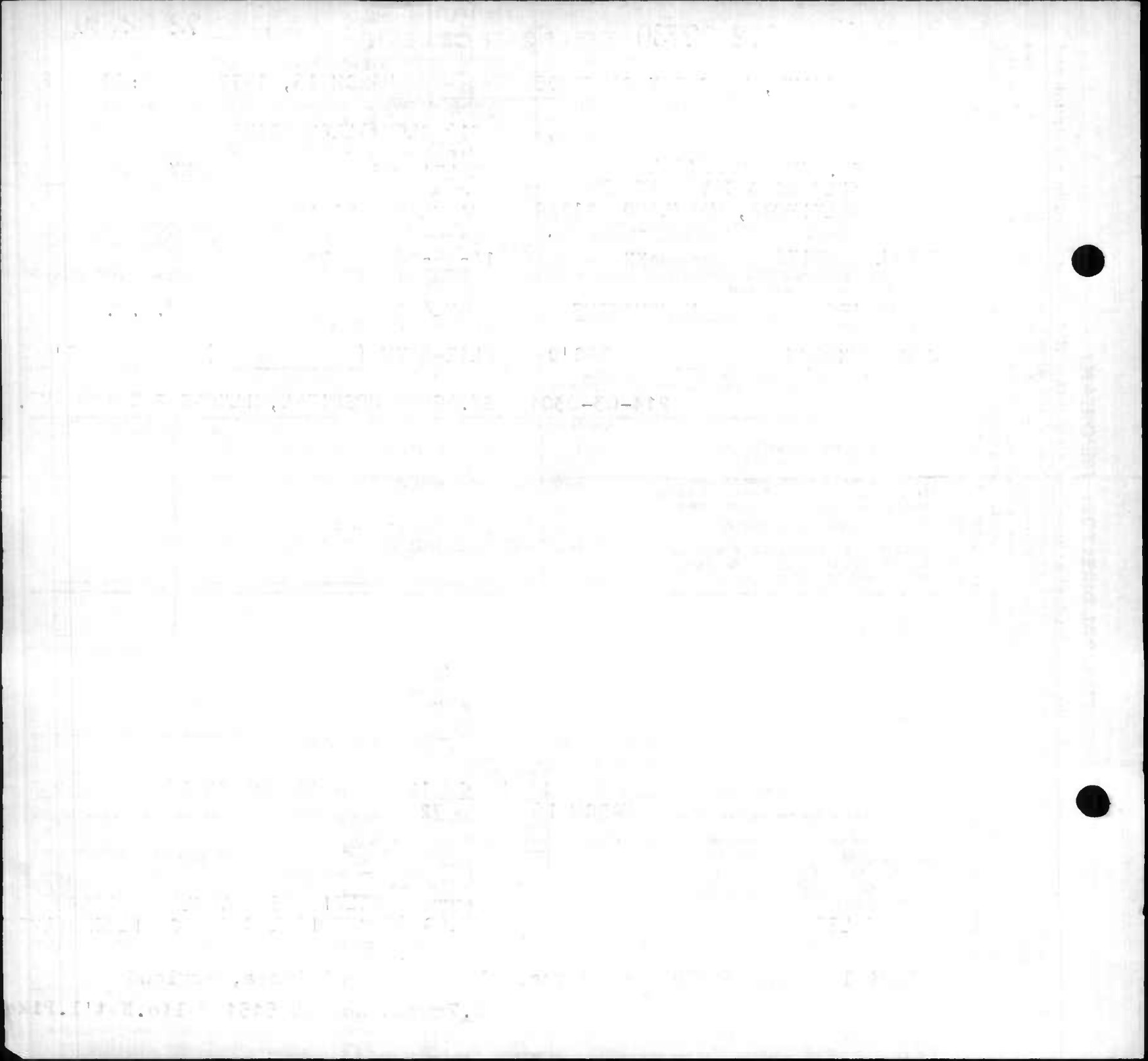
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02729</u>	
D-620 72 02729		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>DORSEY, ELISE</u>		2. DATE AND HOUR OF DEATH <u>MARCH 6, 1972</u> <u>10:10 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD COUNTY</u> <u>6300</u> C. CITY OR TOWN <u>ELLCOTT CITY</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>6899 OAKLAND MILLS RD 21043</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/03</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HAMMOND DORSEY</u>			
14. MOTHER'S MAIDEN NAME <u>ELISE SEILING DORSEY</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>212-30-2405</u>		17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS</u>			
18. <u>444.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>SEPTICEMIA</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Thrombosis Sup. Mesenteric Artery</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>days</u>		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 2</u> 19 <u>72</u> to <u>MARCH 6</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>MARCH 6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. R. Chaney</u>		23B. DATE SIGNED <u>3/6/72</u>		23C. PHYSICIAN'S NAME (Type) <u>C. R. CHANEY MD</u>	
23D. ADDRESS <u>BALTO MARYLAND 21229</u>		23E. ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/9/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>	
24D. LOCATION (City, town, or county) (State) <u>Guilford Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u>		24F. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Donaldson Funeral Home Laurel Md</u>		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

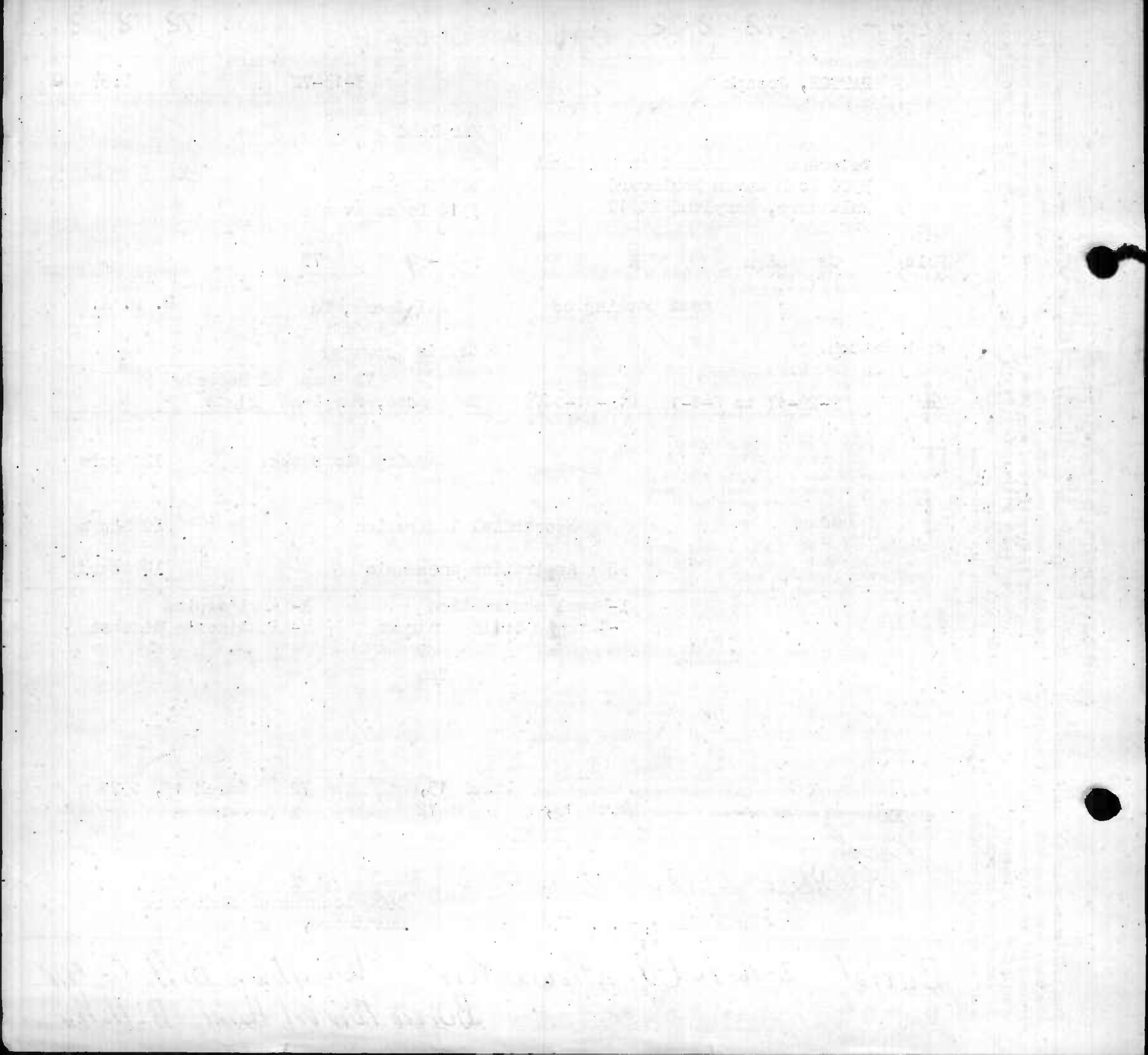
<div style="display: flex; justify-content: space-between;"> B-215 72 02730 CERTIFICATE OF DEATH </div>		REG. NO. 72 02730	
1. NAME OF DECEASED (Type or Print) BUXBAUM, MARGARET GERTRUDE		2. DATE AND HOUR OF DEATH MARCH 16, 1972 9:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <div style="display: flex; justify-content: space-between;"> 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229 </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 514 GLEN ALLEN DRIVE 2834 C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER MARYLAND 21229	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-98
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN BUXBAUM	
14. MOTHER'S MAIDEN NAME ELIZABETH ()		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 214-03-0301		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 12 19 72 to MARCH 16 19 72 that (I) (we) last saw the deceased alive on MARCH 16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE D. S. Lee M.D.		23B. DATE SIGNED March 17, 1972	
23C. PHYSICIAN'S NAME (Type) K LEE		23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/1972	
24C. NAME OF CEMETERY OR CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 5151 Balto. Nat'l. Pike	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-350		72 02732		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02732	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) PATTON, Joseph			
2. DATE AND HOUR OF DEATH 3-13-72 5:55 P M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 1306			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3314 Beech Avenue							
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY meat packing co		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Patton				14. MOTHER'S MAIDEN NAME Garrie Crowther			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9-29-17 to 5-4-19				16. SOCIAL SECURITY NO. 215-01-0475		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218	
18. 486X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Aspiration pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours 12 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 1-Bowel obstruction 3-Parkinsonism 2-Chronic brain syndrome 4-Alzheimer's disease							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 13, 1972 to March 13, 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 13, 1972 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) view view the body after death.							
23A. SIGNATURE Lawrence Mills M.D.				23B. DATE SIGNED 3/15/72			
23C. PHYSICIAN'S NAME (Type) LAWRENCE MILLS, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-16-72		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem		24D. LOCATION (City, town, or county) (State) Woodlawn Bk H Co Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Burke Funeral Home		ADDRESS Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

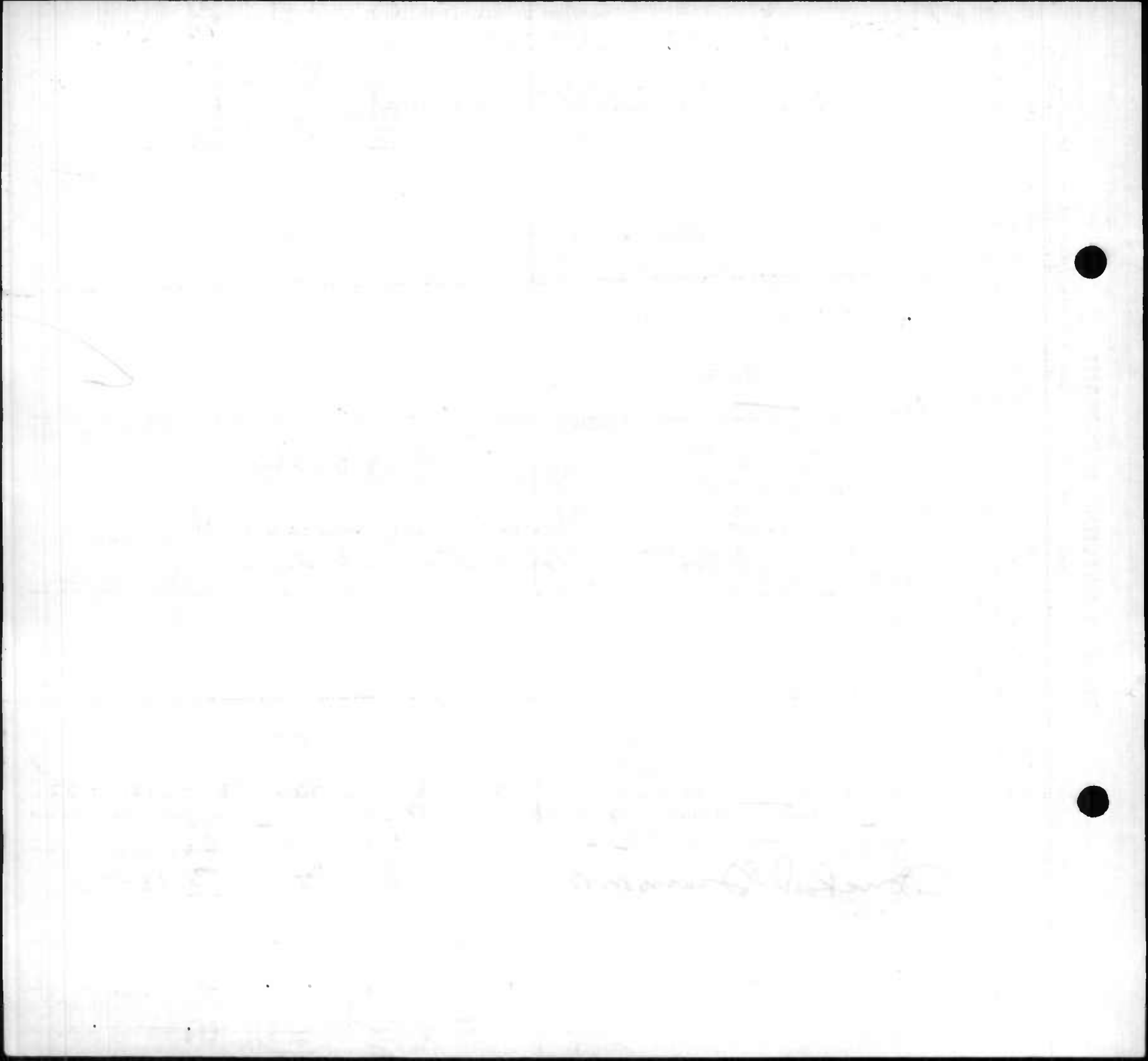
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02731	
C-600 72 02731					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Frances E. Carey			2. DATE AND HOUR OF DEATH March 14, 1972 5:30 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2755		
FULL NAME OF HOSPITAL OR INSTITUTION 90 The Wesley Home, Inc. 2211 West Rogers Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2211 W. Rogers Ave.		
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1886	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Kansas	
13. FATHER'S NAME William Sharples			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218 36 3438D		17. INFORMANT Records Wessley Home
			ADDRESS 2211 W. Rogers Ave.		
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterograde cardiac-vascular disease			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12 December 1971 to 14 March 1972 , that (I) (we) last saw the deceased alive on 9 March 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Barnaby				23B. DATE SIGNED 17 Mar 72	
23C. PHYSICIAN'S NAME (Type) John W. Barnaby M.D.				23D. ADDRESS 1652 E. Belvedere Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 17 1972		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION Parkville Balti. Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 20 1972		24F. NAME OF REGISTRAR 2112 Bayle	
24G. ADDRESS 8631 Falls Rd.		24H. ADDRESS 8631 Falls Rd.		24I. ADDRESS 8631 Falls Rd.	

According to N.H.
Adm. Was in 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-652 72 02733		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02733	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROSD LAWRENCE		2. DATE AND HOUR OF DEATH 3-18-72 9:50P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL		5. CITY OR TOWN HANOVER D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION MD. GENERAL HOSPITAL		E. STREET AND NUMBER Box 7P-A DORSEY RD.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/04	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days: Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Frederick Lawrence		14. MOTHER'S MAIDEN NAME Ellie Lee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-7723		17. INFORMANT Mrs. Regina C. Thompson ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable stroke		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable stroke		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Branchogenic cancer with		(B) DUE TO, OR AS A CONSEQUENCE OF: Probable metastasis			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-18-72 to 3-18-72 that (I) (we) last saw the deceased alive on 3-18-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald J. Russo M.D. DEGREE				23B. DATE SIGNED 3-18-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cent.	
24D. LOCATION (City, town, or county) (State) Balto, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Rebecca		25C. FUNERAL DIRECTOR Edgell Funeral Home 130 E. Fort Ave. 21230	



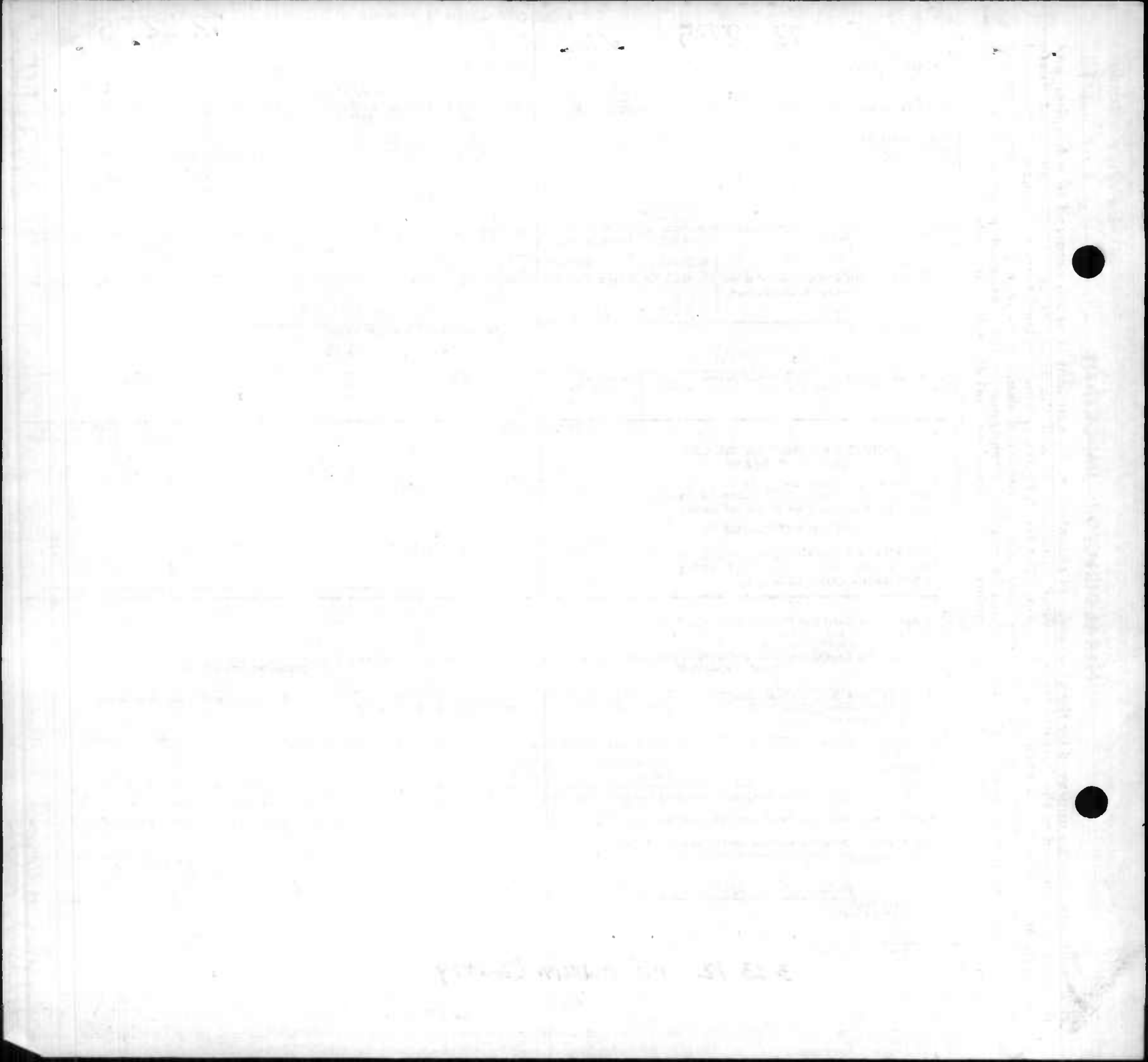
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-563		72 02734		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02734	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Catherine Reinhardt				2. DATE AND HOUR OF DEATH March 16, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Edgewood Nursing Home 6000 Bellona Avenue Baltimore, Maryland 21212				A. STATE B. COUNTY Maryland Baltimore			
				C. CITY OR TOWN Pikesville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 7101 Plymouth Road 21208			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1887	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Louis Wode				14. MOTHER'S MAIDEN NAME Rose ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No None				16. SOCIAL SECURITY NO. 216-03-2684		17. INFORMANT Pikesville, Md. 21208 ADDRESS Mrs. Genevieve Branick 7101 Plymouth Road	
18. 437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Anterior Arteriosclerosis (B) Cerebral Anterior Arteriosclerosis (C) Cerebral Anterior Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years. years.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 14 1971 to March 16 1972 that (we) last saw the deceased alive on March 16 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Anthony F. Carozza				23B. DATE SIGNED 3/16/1972			
23C. PHYSICIAN'S NAME (Type) ANTHONY F. CAROZZA				23D. ADDRESS 5217 YORK Rd BALTO Md 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/1972		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie Anne Arundel Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR R. E. Jones		25C. FUNERAL DIRECTOR Loring Byers Funeral Directors, P. A.		8728 Liberty Road ADDRESS 21133	

[The page contains extremely faint, illegible markings and bleed-through from the reverse side.]

Lawrence Strong
21 66 27

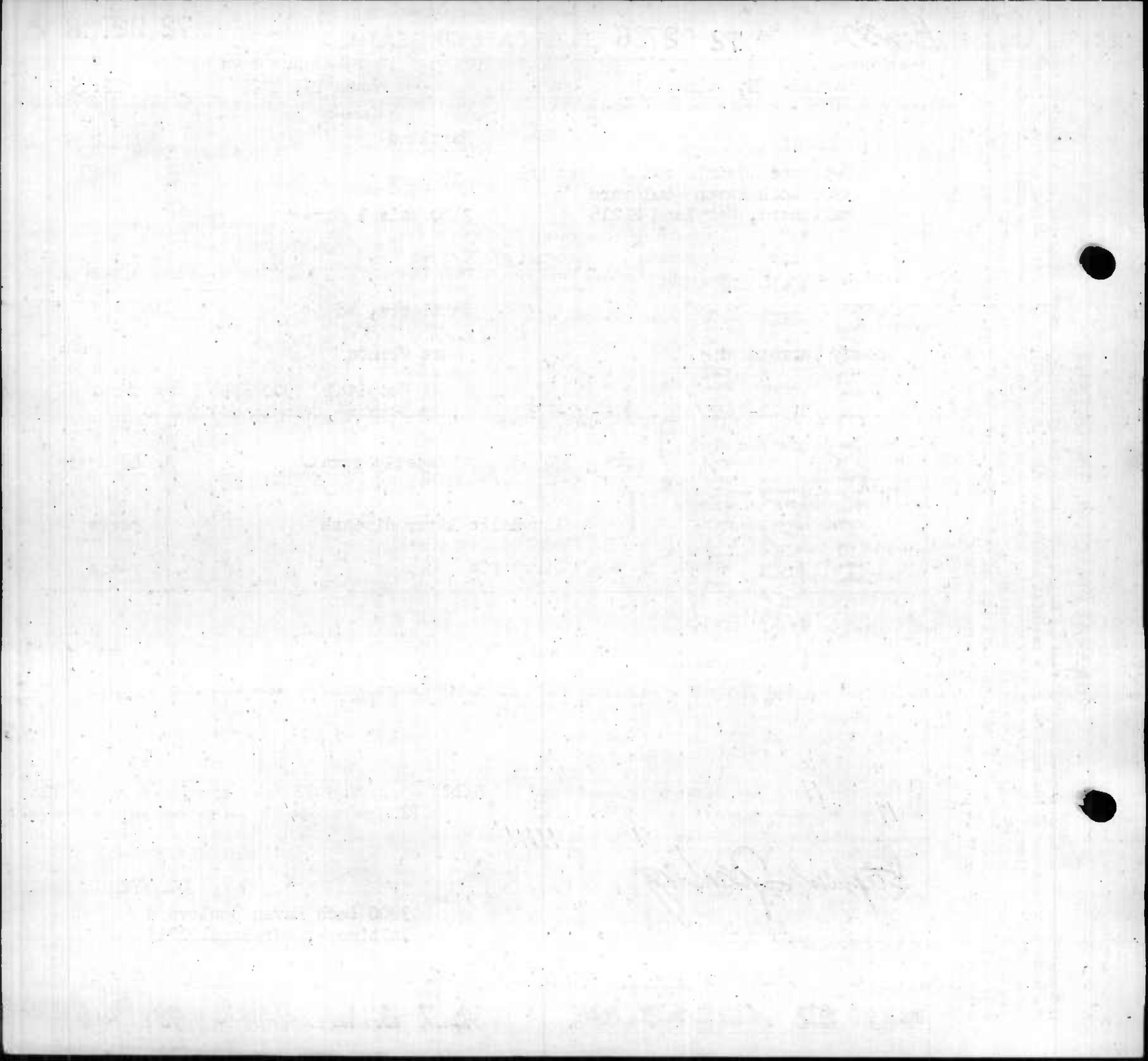
S-365		72 02735		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02735	
BIRTH NO.		72 02735		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) STRONG, LAWRENCE				2. DATE AND HOUR OF DEATH 03/16/72 9:05 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 361			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 336 S. DALLAS COURT			
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/03/14	
				9. AGE (in years last birthday) 57		11. BIRTHPLACE (State or foreign country) South Carolina	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY Contractor		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME STRONG, PERRY				14. MOTHER'S MAIDEN NAME LIES, PEGGY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215 09 5067		17. INFORMANT Mr Daniel Strong, 2341 W North Ave	
18. 412.4 17 011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CORONARY ARTERY DISEASE + CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1. Pulmonary TBC 2. Pneumonia 3. G.F. Bleeding				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 10+ years P Months 3 days 7 Days			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from March 4, 1972 to March 16, 1972 that (1) (we) last saw the deceased alive on March 16, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did not) view the body after death.							
23A. SIGNATURE Thomas H. Hodous M.D.				23B. DATE SIGNED 3/16/72			
23C. PHYSICIAN'S NAME (Type) THOMAS H. HODOUS, M. D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME OF CEMETERY OR CREMATORY MT. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-632</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02736</u>			
1. NAME OF DECEASED (Type or Print) <u>HARTHAUSER, Wilbert P</u>				2. DATE AND HOUR OF DEATH <u>March 15, 1972</u> <u>12:45 P</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23</u> <u>Veteran Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2553</u>							
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>1/6/18</u> 9. AGE (In years last birthday) <u>54</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10B. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>					
13. FATHER'S NAME <u>Thomas Harthausen</u>				14. MOTHER'S MAIDEN NAME <u>Laura Vernon</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>6/25/41-8/12/45</u>				16. SOCIAL SECURITY NO. <u>705-12-5292</u>		17. INFORMANT <u>VA Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218</u>					
18. <u>571.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hepatic coma</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Alcoholic liver disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cirrhosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>years</u> <u>years</u>					
MEDICAL CERTIFICATION 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)							
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
21F. HOW DID INJURY OCCUR?				22. I certify that <u>W</u> (this hospital) attended the deceased from <u>3/11</u> 19 <u>72</u> to <u>3/15</u> 19 <u>72</u> , that <u>W</u> (we) last saw the deceased alive on <u>3/15</u> 19 <u>72</u> and that in <u>W</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>W</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stephen Greenberg</u> 23B. DATE SIGNED <u>3/17/72</u>				23C. PHYSICIAN'S NAME (Type) <u>STEPHEN GREENBERG, M.D.</u> 23D. ADDRESS <u>3900 Loch Raven Boulevard Baltimore, Maryland 21218</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>3/20/72</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Bethel National Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>Bethel, Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u> 25B. NAME OF REGISTRAR <u>Barbara J. Jones</u>				25C. FUNERAL DIRECTOR <u>Barbara J. Jones</u> ADDRESS <u>901 Hollins St. Balt. 21223</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-520		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02737
1. NAME OF DECEASED (Type or Print) WALTER JOSEPH RUNGE		2. DATE AND HOUR OF DEATH 03/17/72 11:07p , M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 603		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 02/28/99		9. AGE (In years last birthday) 73		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Livery Service		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ANTON RUNGE		
14. MOTHER'S MAIDEN NAME JOSEPHINE ZOUBEK		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 212 12 9969		17. INFORMANT ADDRESS Marie J. Runge 229 N. Duncan St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiorespiratory collapse DUE TO, OR AS A CONSEQUENCE OF: (B) cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF: (C) Sepsis, COPD, CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Old tuberculosis				
19A. DATE OF OPERATION 2-22-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 2/28 19 72 to Mar 17 19 72 that (1) (we) last saw the deceased alive on Mar 17 19 72 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Martha L. Kopper, M.D.		23B. DATE SIGNED 3/17/72		23C. PHYSICIAN'S NAME (Type) MARTHA L. KOPPER, M. D.
23D. ADDRESS Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3-21-72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Philip E. Vach		25C. FUNERAL DIRECTOR ADDRESS 1211 Chesaco Ave

17 may 55



2/58
55

17 may 55



3/18/55

N

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02738	
BIRTH NO. 72 02738		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Binko, Jr.		2. DATE AND HOUR OF DEATH 3-14-1972 12.53 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1649 Manor Road 21222					
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-1924	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spot-Welder		10B. KIND OF BUSINESS OR INDUSTRY Raymond Metals		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John A. Binko		14. MOTHER'S MAIDEN NAME Susie M. Goffus			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-14-2281		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave., 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiorespiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction (C) thoracic hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 1 hour ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/14 1972 to 3/14 1972 that (I) (we) last saw the deceased alive on 3/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Roll		23B. DATE SIGNED 3/14/72			
23C. PHYSICIAN'S NAME (Type) Joseph Roll		23D. ADDRESS Baltimore, Md. Baltimore City Hospitals, 4940 Eastern Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. Duda	
25D. ADDRESS 7922 Wise Ave. Dundalk, Md. 21222					

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Handwritten signature or name, possibly "Joseph B. ..."]

[Faint handwritten text below the signature.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02739

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Pierson (Pearson) Wilson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 13 72 9:24 P. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 528 Robert Street		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 13 72 9:24 P. M.			
6. SEX Male		7. RACE Negro			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1403			
9. DATE OF BIRTH 9-11-02		10. AGE (In years last birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
15. MOTHER'S MAIDEN NAME Ida		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
17. SOCIAL SECURITY NO. 217-01-8147		18. INFORMANT Henrietta Jones 533 Robert Street			
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		DATE SIGNED 3-14-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-72			
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Wm G March		ADDRESS 928 E North Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02740	
BIRTH NO. P-240		T512 72 02740		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) THOMPSON PASCHALL, Foster			2. DATE AND HOUR OF DEATH 3/14/72 1:40 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2605 E. Preston Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/17/34	9. AGE (In years last birthday) 37	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Elijah Jackson			14. MOTHER'S MAIDEN NAME Emma Paschall		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-30-1714		17. INFORMANT ADDRESS Emma Thompson 2605 E. Preston Street	
18. 508.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) EPIGLOTTITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/14 19 72 to 3/14 19 72 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/14 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE James Heroy, M.D.				23B. DATE SIGNED 3/17/72	
23C. PHYSICIAN'S NAME (Type) James Heroy,		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Ctyl, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972			
25B. NAME OF REGISTRAR Robert E. Fisher, R.D.O.		25C. FUNERAL DIRECTOR ADDRESS Win C March 928 E North Ave.			

The volume of the...

...

...

...

...

...

...



...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

M-265

72 02741

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02741

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LEANDER McCORMICK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2038 E. Biddle Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 16, 1972 10:30 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-6-08		10. AGE (In years last birthday) 64	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Annie Morgan		18. INFORMANT ADDRESS Doretha Mayo - 2038 E. Biddle Street	
19. 174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Carcinoma of Breast (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/18/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Eagle Rock, N.C.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert A. Kelly, M.D.	
25C. FUNERAL DIRECTOR Wm J. March		ADDRESS 928 E. North Avenue	

1955

1955

WALLLEY BONDING

WALLLEY BONDING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) DELPHINE J. WARRINGTON		2. DATE AND HOUR OF DEATH MARCH 15, 1972 12.30A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1547 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2213 BRADDISH	
5. SEX F	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/08
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REI. TEACHER		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 63
11. BIRTHPLACE (State or foreign country) Baltimore MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW JOHNSON		14. MOTHER'S MAIDEN NAME CASSIE MOORLY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-40-4813	
17. INFORMANT William T. Warrington		ADDRESS 2213 Braddish Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 246X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: renal organ death (B) s/p Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Mar 72			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Multiple Sclerosis			
19A. DATE OF OPERATION 10 Mar 72	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED transient abdominal	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) no	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no	21C. WHERE DID INJURY OCCUR no	(If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) no	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> no	21F. HOW DID INJURY OCCUR? no	
22. I certify that (1) (this hospital) attended the deceased from 9 March 1972 to 15 March 1972 that (1) (we) last saw the deceased alive on 15 March 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John Tarpley M.D.		23B. DATE SIGNED 15 March 72	
23C. PHYSICIAN'S NAME (Type) JOHN TARPLEY, M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Bural	24B. DATE 3/18/72	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Mary-E. Law	
25C. FUNERAL DIRECTOR 802 Madison Ave.		ADDRESS	

50-10-30-40

Handwritten notes, possibly "Handwritten notes" and "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

Handwritten notes, possibly "Handwritten notes".

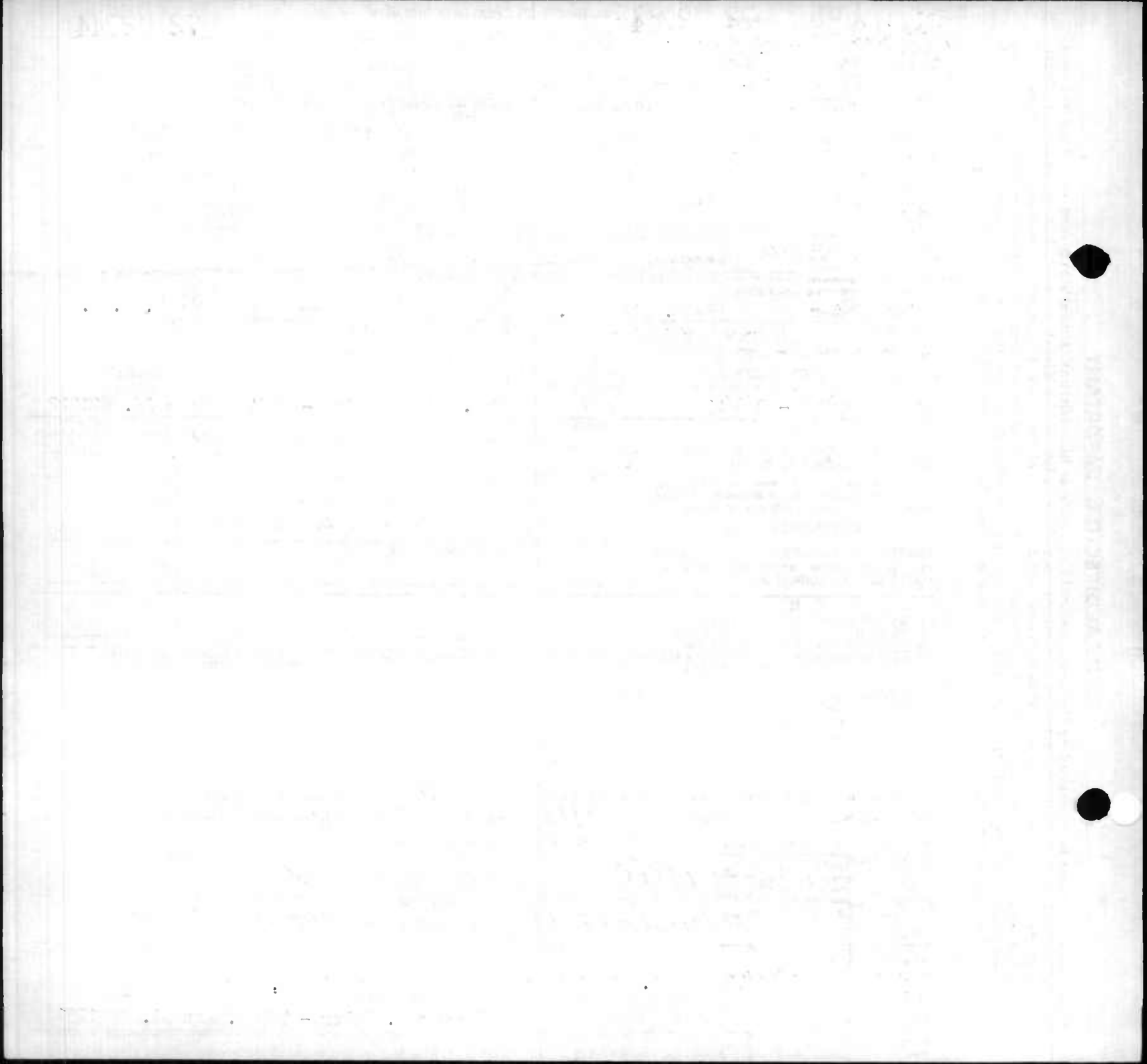
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-560		72 02743		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02743	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Ernest Joyner Jr.			
2. DATE AND HOUR OF DEATH 3-16-72 1 5 ⁴⁵ a. m.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland 1547		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2904 Clifton Av.	
5. SEX m	6. RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-33	9. AGE (in years lost birthday) 39	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Joyner Sr.				14. MOTHER'S MAIDEN NAME Bertha Hilliard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Barbara Joyner 2904 Clifton Ave.			
18. 43101 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PONTINE hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension Dyslipidemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 3-16-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED dx study		20A. AUTOPSY? (Yes or No) No Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3-14-72 19 to 3-16 1972 that (I) (we) last saw the deceased alive on 3-16-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Wolfram REICHL				23B. DATE SIGNED 3-16-72		23C. PHYSICIAN'S NAME (Type) Wolfram REICHL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72		24C. NAME of CEMETERY or CREMATORY Arbustus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Mary-E. Law		25C. FUNERAL DIRECTOR Mary-E. Law		25D. ADDRESS 802 Madison Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

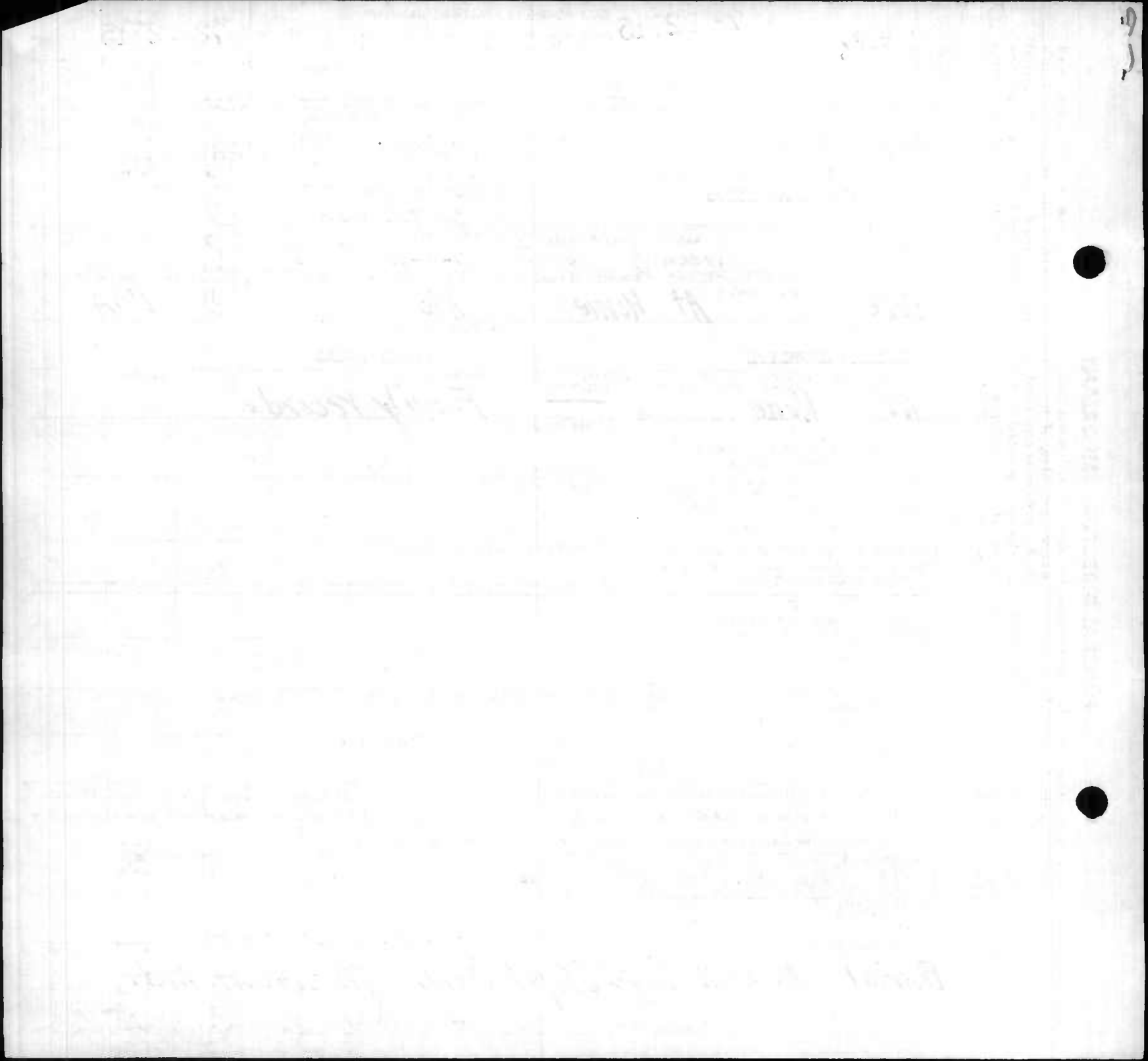
<div style="display: flex; justify-content: space-between;"> T-622 72 02744 </div>		<div style="display: flex; justify-content: space-between;"> Frank Turkiewicz CERTIFICATE OF DEATH </div>		<div style="display: flex; justify-content: space-between;"> REG. NO. 72 02744 </div>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) TURKIEWICZ - FRANK		2. DATE AND HOUR OF DEATH 3/17/72 9:40 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital 120 North Broadway.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND - B. COUNTY BALTIMORE 603 C. CITY OR TOWN city D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 16 N. BROADFORD Street 21224			
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13-190	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Andrew Turkiewicz ?		14. MOTHER'S MAIDEN NAME Anna	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/7/20 - 9/6/23		16. SOCIAL SECURITY NO. 21309 3969		17. INFORMANT ADDRESS Mrs. Frances Giza - 8054 Wallace Rd. #21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 440.9 I BRONCHOPNEUMONIA ASPIRATION		CAUSE OF DEATH BRONCHOPNEUMONIA ASPIRATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediately	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO SCLEROSIS VASCULAR DISEASE		chronic	
		(B) DUE TO, OR AS A CONSEQUENCE OF: CHRONIC BRAIN SYNDROME		years.	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Identify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/5/72 19 to 3/17/72 19 that (I) (we) last saw the deceased alive on 3/17/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Impagliatelli		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) WALKER - IMPAGLIATELLI		23D. ADDRESS 100 NORTH BROADWAY ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR ADDRESS George A. Weber - 705 S. Ann St. #21231	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> B-143 72 02745 CERTIFICATE OF DEATH REG. NO. 72 02745 </div>	
BIRTH NO. 66-14532	
1. NAME OF DECEASED (Type or Print) <u>Lisa Baublitz</u>	
2. DATE AND HOUR OF DEATH <u>3/13/72</u> <u>1:30 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HARFORD</u> C. CITY OR TOWN <u>JOPPA</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>121 FERN DRIVE</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>07-16-66</u>	
9. AGE (In years last birthday) <u>5</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tube</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM BAUBLITZ</u>	
14. MOTHER'S MAIDEN NAME <u>NANCY LUCAS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>Family records</u>	
17. INFORMANT ADDRESS	
18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cystic Fibrosis of Pancreas</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION <u>2</u>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> 19 <u>72</u> to <u>3/13</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Michael V. Johnston, M.D.</u> DEGREE	
23B. DATE SIGNED <u>3/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael V. Johnston, M.D.</u> DEGREE	
23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	
24B. DATE <u>Mar. 16, 1972</u>	
24C. NAME of CEMETERY or CREMATORY <u>Mary's Chapel Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u>	
25B. NAME OF REGISTRAR <u>JOHN BURNS' SONS</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>TOWSON, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

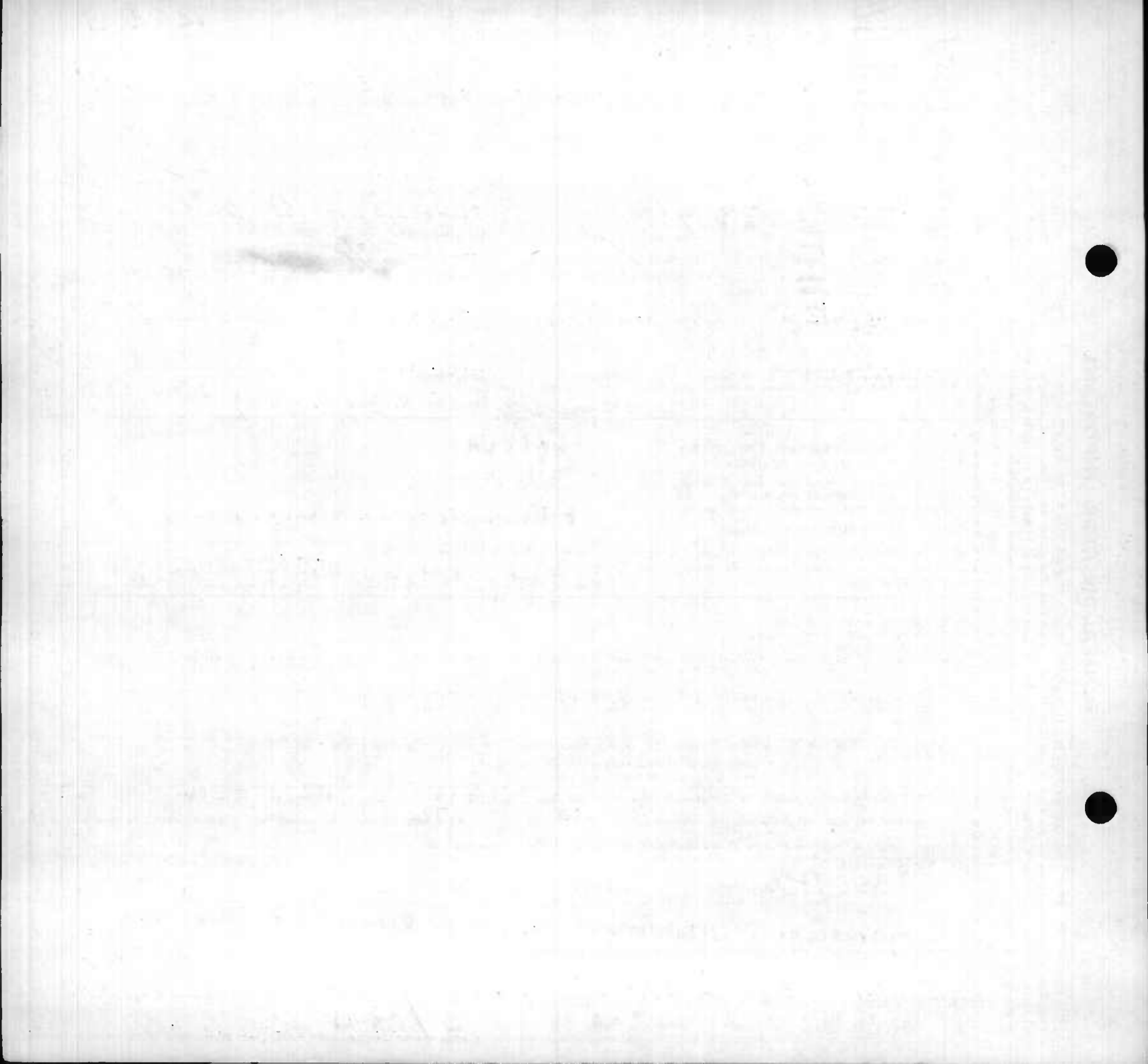
BALTIMORE CITY HEALTH DEPARTMENT				72 02746		72 02746	
S-235				72 02746		72 02746	
1. NAME OF DECEASED (Type or Print) SERTON, WALTER J.				2. DATE AND HOUR OF DEATH 3-17-72 9³⁰ A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2505			
FULL NAME OF HOSPITAL OR INSTITUTION 43 So. BALTIMORE GEN. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 So. HANOVER ST, BALTO		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY MACHINIST		9. AGE (In years, last birthday) 86		11. BIRTHPLACE (State or foreign country) ENGLAND	
13. FATHER'S NAME TITOMAS J				14. MOTHER'S MAIDEN NAME MARY MYERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-6768-A		17. INFORMANT NEPHEW		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the type of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease Cardiac Arrest Arteriosclerotic Heart Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fracture Pelvic Bone				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pelvic Fracture							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4934 Pennington Ave			
21D. TIME OF INJURY (APPROX.) 2-29-72 5⁴⁵ PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL FROM FLOOR while getting up from table			
22. I certify that (I) (this hospital) attended the deceased from 2-29-72 to 3-17-72 and that (I) (we) last saw the deceased alive on 3-17-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 3-17-72		23C. PHYSICIAN'S NAME (Type) SIHAAN	
23D. ADDRESS 50. BALTO. GEN. HOSP.		23E. FUNERAL DIRECTOR ATLANTA FUNERAL HOME					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-20-72		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS		24D. LOCATION (City, town, or county) (State) RITCHIE HWY BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ATLANTA FUNERAL HOME			

88

FUNERAL DIRECTOR: IMPORTANT

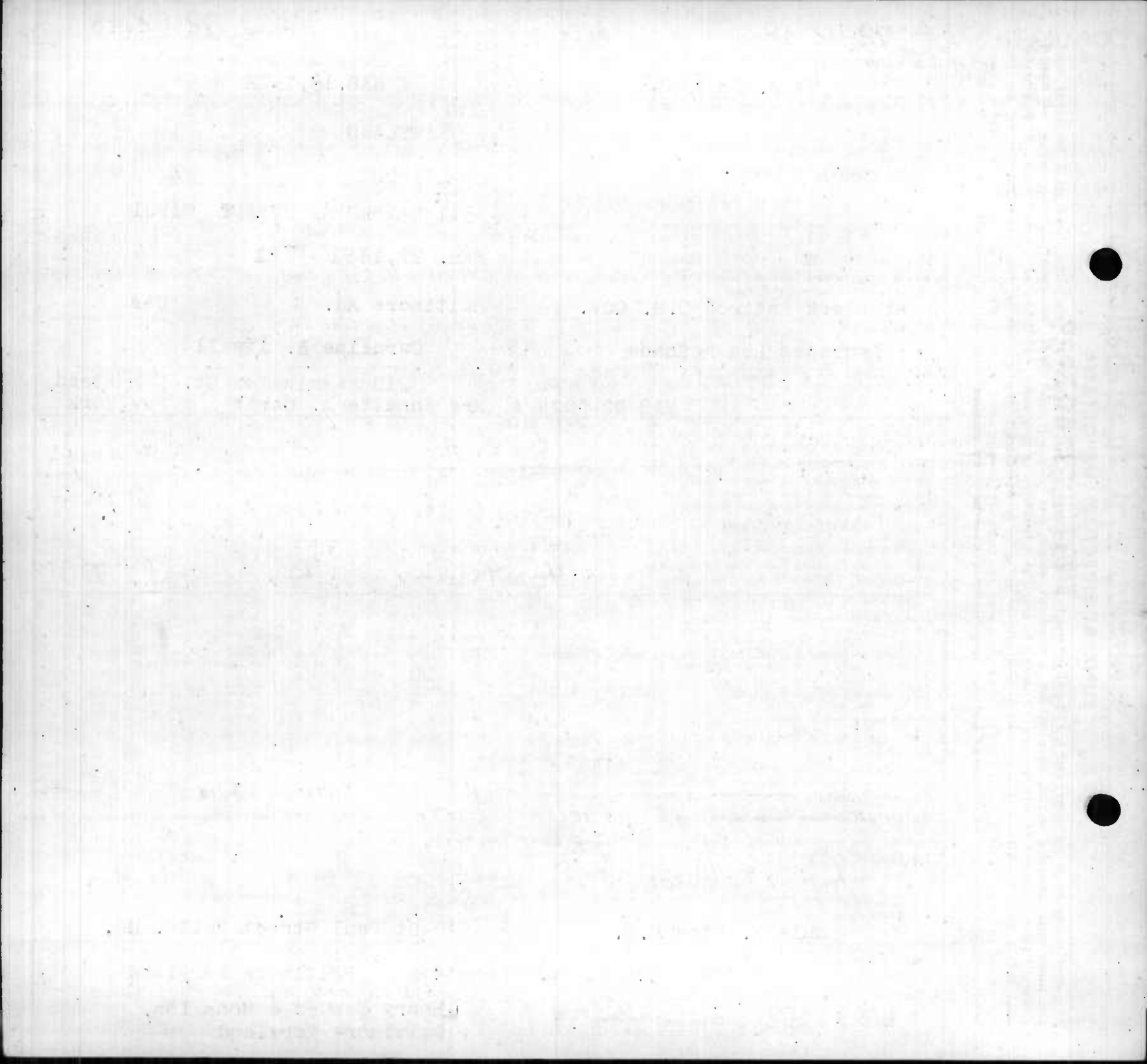
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02747		REG. NO. 72 02747	
BIRTH NO. C-640		72 02747		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Tanie Carroll or Jannie Carroll		2. DATE AND HOUR OF DEATH 3-14-72 12:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 833			
FULL NAME OF HOSPITAL OR INSTITUTION Lake Drive Nursing Home 2401. Eutaw Place Baltimore, Md. 21217		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
S. SEX Fe 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 4-18-1916 9. AGE (In years last birthday) 55		11. Under 1 Yr. Months: Days: 12. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Ayden, N.C.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 240-03-8271A		17. INFORMANT William Killfrey (nephew) ADDRESS 2604 E. Oliver St. (13)	
18. 412.3 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		left CVA		Several Months	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Many Years	
ANTECEDENT CAUSES		Arteriosclerotic cardiovascular disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		ASIA & chronic stroke			
		(C) CHF			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-13-1972 to 3-14-1972 , that (I) (we) last saw the deceased alive on 3-10-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Arthur DEGREE MD				23B. DATE SIGNED 3-14-72	
23C. PHYSICIAN'S NAME (Type) WILLIAM F. ARBUERNE MD DEGREE				23D. ADDRESS 7935 PIPERS PATH STON BURNING MD 21060	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-18-72		24C. NAME of CEMETERY or CREMATORY St. Mary's Calvary Cemetery	
24D. LOCATION (City, town, or county) Anne Arundel Co., Md.		24E. NAME of REGISTRAR Randolph J. Collick		24F. FUNERAL DIRECTOR ADDRESS 2431 E. Oliver St.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972 25B. NAME OF REGISTRAR Valerie E. [unclear] 25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

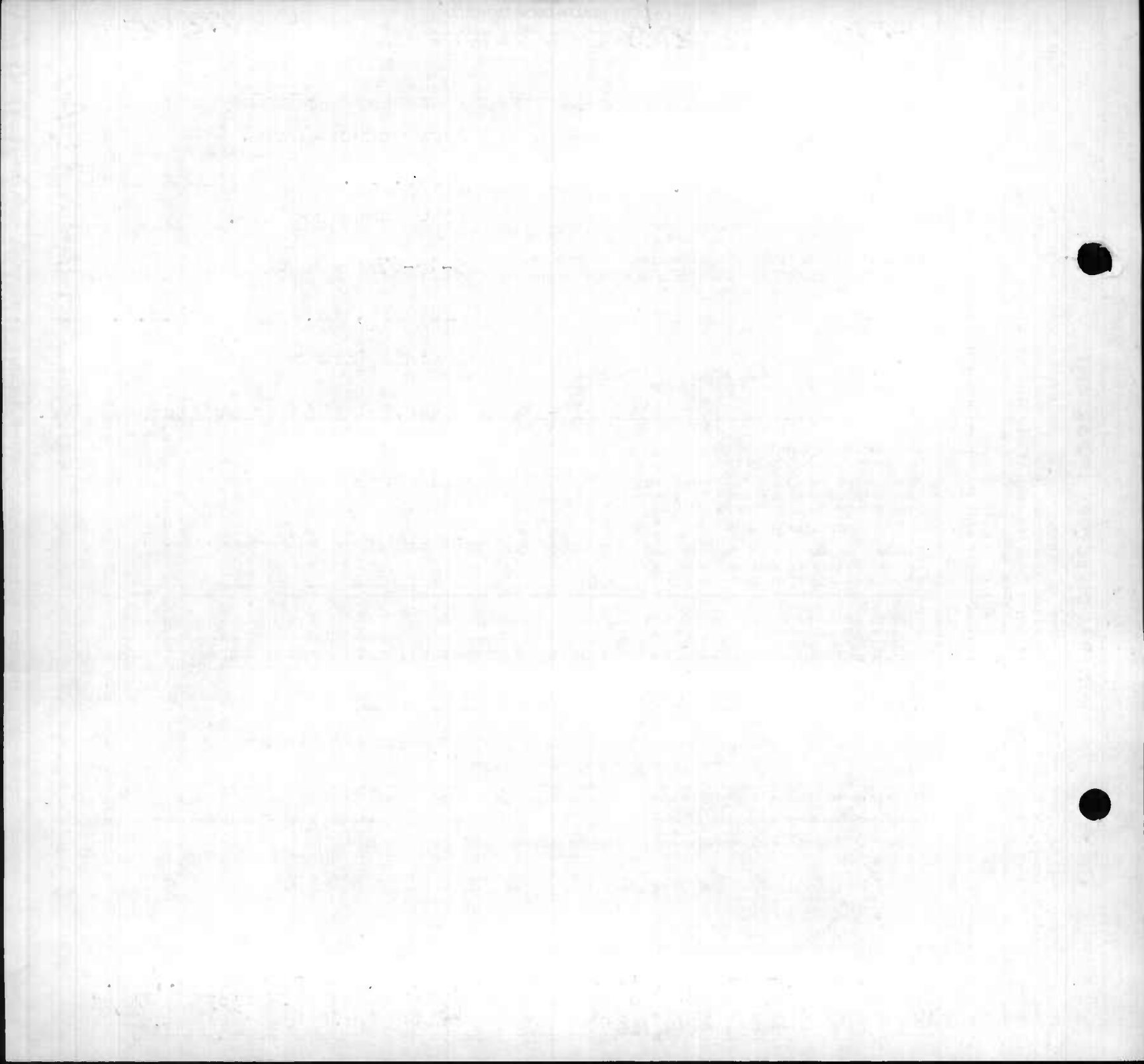
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02748	
72 02748				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) ALMA A. McSHANE			2. DATE AND HOUR OF DEATH MAR. 18, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ANDERSON NURSING HOME 3604 MOHAWK AVENUE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 401		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 311 CATHEDRAL STREET 21201		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1891		9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief clerk Retired U.S. GOV.			11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lawrence Lee McShane			14. MOTHER'S MAIDEN NAME Caroline B. Atwell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218 22 0024 A	17. INFORMANT 10 Washington St. Hampstead Mrs Annette A. Davis New York		
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C. V. A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cerebral sclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C.V.D.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 6 mos. 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/4/1971 to 3/18/1972 , that (I) (we) last saw the deceased alive on 3/16/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis E. Wice M.D.			Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/20/72
23C. PHYSICIAN'S NAME (Type) Louis E. Wice M.D.			23D. ADDRESS 920 St Paul Street Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR'S ADDRESS Henry Sander & Sons Inc. Baltimore Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02749	
72 02749				CERTIFICATE OF DEATH	
BIRTH NO. S-432					
1. NAME OF DECEASED (Type or Print) Virginia Shields			2. DATE AND HOUR OF DEATH 3-18-72 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2590 Edmondson Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1605 C. CITY OR TOWN Balto. Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2590 Edmondson Ave.		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-07	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Liston Davis			14. MOTHER'S MAIDEN NAME Virginia Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-10-1881D		17. INFORMANT Herbert Shields 605 Augusta Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 582X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia DUE TO, OR AS A CONSEQUENCE OF: Chronic renal failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED Wife At Work <input type="checkbox"/> Not Wife At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-24-72 19 to 3-1- 19 72 . that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Robert Cooke DEGREE				23B. DATE SIGNED 3-18-72	
23C. PHYSICIAN'S NAME (Type) E. Robert Cooke DEGREE				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-72		24C. NAME OF CEMETERY OR CREMATORY Shields Cemetery	
24D. LOCATION (City, town, or county) (State) Lancaster Co., Va.					
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Bailey		25C. FUNERAL DIRECTOR Kelson P.H.	
ADDRESS 1348 Calhoun Street					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-160 72 02750				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02750	
BIRTH NO. 72 04710				72 02750		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Cooper Baby Boy				2. DATE AND HOUR OF DEATH 3-13-72		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md 21229 B. COUNTY 102			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3929 E. Baltimore St			
5. SEX Male	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-72	9. AGE (In years last birthday) Newborn	10. Under 1 Yr. Months 12 Days 43	11. Under 24 Hrs. Min. 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hospital		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME David Martin Busick				14. MOTHER'S MAIDEN NAME Rose Marie Ash			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 740X I Hypoglycemia				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypoglycemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: Primary insufficiency			
				(C) DUE TO, OR AS A CONSEQUENCE OF: Hypocapnia			
19A. DATE OF OPERATION 2/1				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 13 March 1972 to 13 March 1972 that (I) (we) last saw the deceased alive on 13 March 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Neil N. Senzer				23B. DATE SIGNED 3/13/72			
23C. PHYSICIAN'S NAME (Type) Neil N. Senzer, M.D.				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3/13/72		24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Hospital		24D. LOCATION (City, town, or county) (State) 601 N Broadway, Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert J. Bailey		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHO			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-530		72 02751		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02751	
1. NAME OF DECEASED (Type or Print) Paul Smith				2. DATE AND HOUR OF DEATH 3/11/72 2:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Frederick C. CITY OR TOWN Rural Frederick D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Rt. 7-Bethel Road			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-28	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel (dec)				14. MOTHER'S MAIDEN NAME Bertha Orme			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean Conflict		16. SOCIAL SECURITY NO. 212-24-6702		17. INFORMANT BCH-RECORDS ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gran Negative Sepsis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Rectal & Perineal Abscess OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Acute Myelocytic Leukemia Coronary Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 2/28/1972 to 3/11/1972 that (X) (we) last saw the deceased alive on 3/11/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. S. Goldberg, M.D.				23B. DATE SIGNED 3/11/72		23C. PHYSICIAN'S NAME (Type) H. S. Goldberg, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-13-1972		24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frederick, Frederick, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Bailey, Jr.		25C. FUNERAL DIRECTOR Robert E. Bailey & Son		ADDRESS Frederick, Maryland	

3/1/52

675 1st St. N.W.

George Washington
Hotel
Front Right of Center
Curtain 12 ft. wide

3/1/52

4-27-52

3/1/52

C-400

72 02752 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02752

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY COLE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour March 18, 1972 9:10 A. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 302							
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 72	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 924 Watson Street		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Clinton Fields		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			14B. KIND OF BUSINESS OR INDUSTRY Home		15. MOTHER'S MAIDEN NAME Margaret		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr Benjamin Cole, same		
19. 412.4 + 011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Arteriosclerotic cardiovascular disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary tuberculosis			21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/19/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W north Ave	

8-51-57

50/100 100/100

WALLLEY FORMS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02753	
BIRTH NO. 72 02753					
1. NAME OF DECEASED (Type or Print) Vincent T. Marsiglia		2. DATE AND HOUR OF DEATH 3/17/72 15:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Howard C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2941 Normandy Drive, Ellicott City			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/19	9. AGE (In years last birthday) 53	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10B. KIND OF BUSINESS OR INDUSTRY Lex. market		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME (deceased) Anthony Marsiglia		14. MOTHER'S MAIDEN NAME (deceased) Carmella Marsiglia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 213-34-1169		17. INFORMANT Mrs. Esther Marsiglis, 2941 Normandy Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 20221 Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Terminal state of malignancy DUE TO, OR AS A CONSEQUENCE OF: (B) Possible lymphoma DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-10-1972 19 to 3-17-1972 19 that (I) (we) last saw the deceased alive on 3-17-72 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Vilaivum Thitivaranan		23B. DATE SIGNED 3-17-72		23C. PHYSICIAN'S NAME (Type) Vilaivum Thitivaranan	
23D. ADDRESS Bon Secour Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3/21/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. J. J. MD.		25C. FUNERAL DIRECTOR ADDRESS W. J. J. 1630 Edmondson Avenue 21228	

17-11-1911

Received of Mr. J. H. Jones

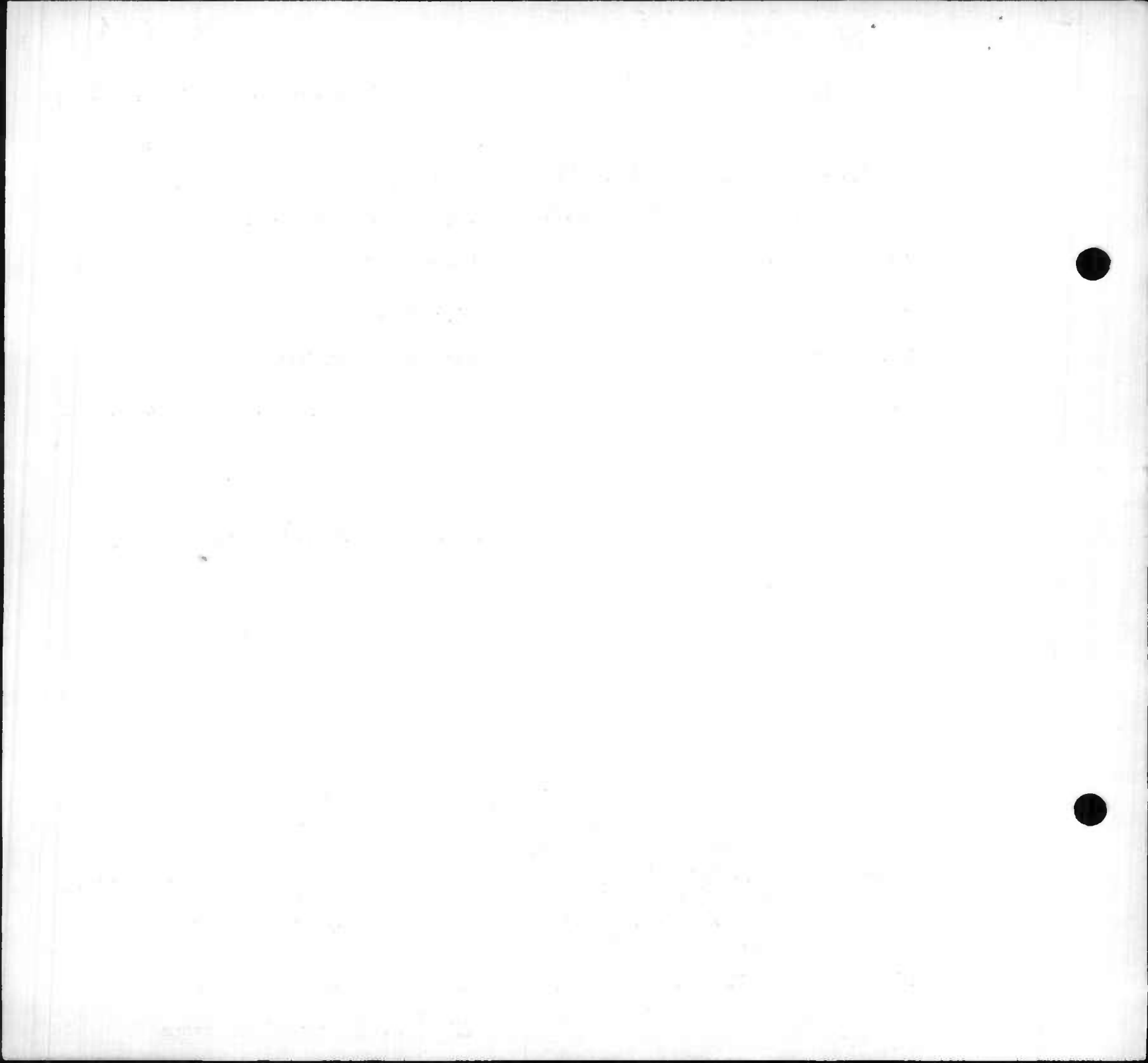
the sum of £100

for the purchase of 100 shares

of the company of which

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

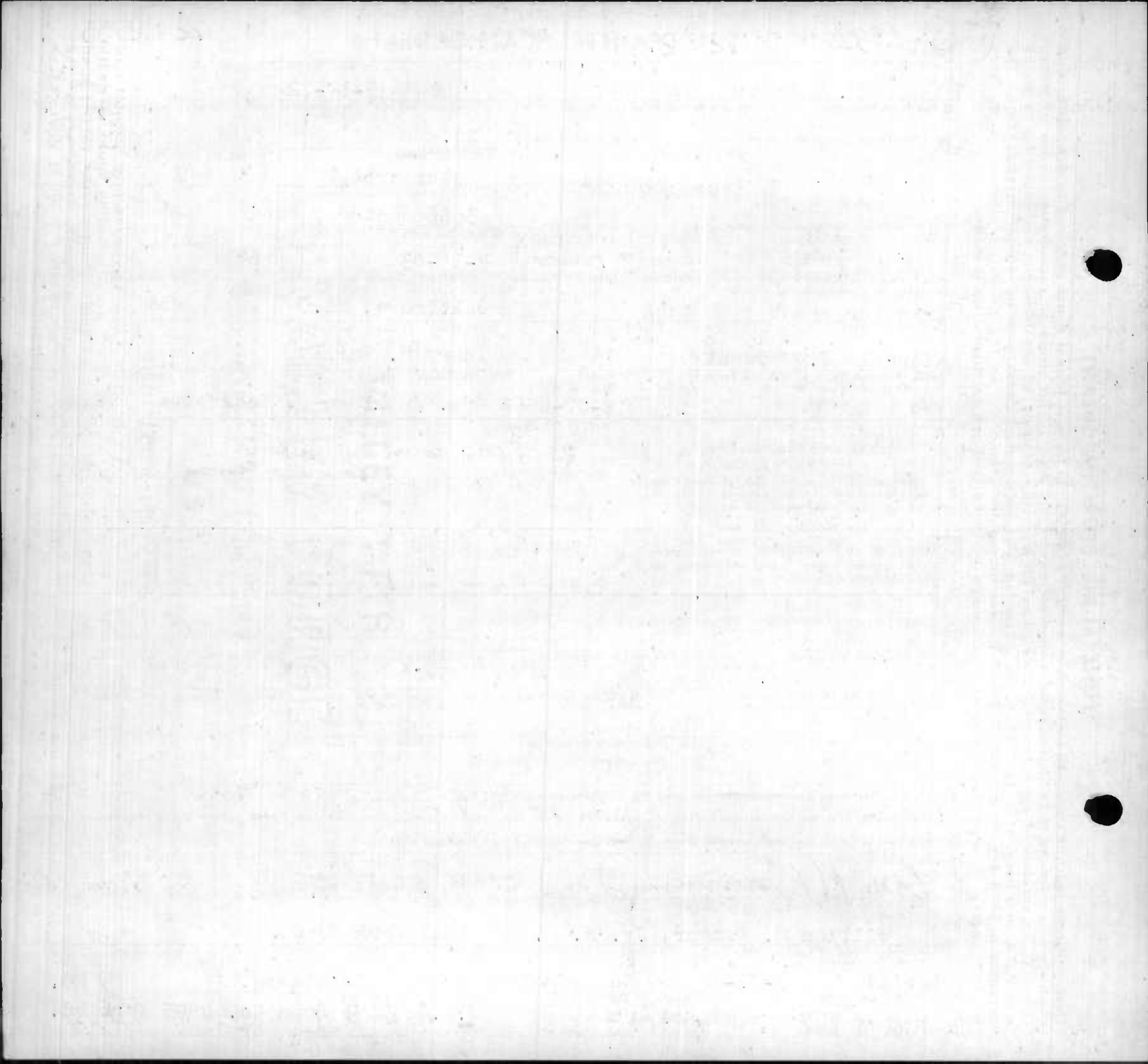
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02754
BIRTH NO. 72 02754				
1. NAME OF DECEASED (Type or Print) Raymond R. Moore		2. DATE AND HOUR OF DEATH March 13 1972 11 55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md B. COUNTY 2716		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hosp. of Balt. Baltimore Md. 21215		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 3305 Woodland Avenue 21215		
5. SEX M	6. RACE Cav	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-56	9. AGE (in years last birthday) 16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Earl Moore		14. MOTHER'S MAIDEN NAME Leona Moore (Cuminey)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Cathryne Phifer, 312 E. Oliver St., 21202
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF: (B) Corruption of Aorta DUE TO, OR AS A CONSEQUENCE OF: (C)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/12 19 72 to 3/13 19 72 that (I) (we) last saw the deceased alive on 3/13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Morris Ostroff		23B. DATE SIGNED 3/15/72		
23C. PHYSICIAN'S NAME (Type) Morris Ostroff		23D. ADDRESS Sinai Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/18/72		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery
24D. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Ditzke, 11630 Edmondson Avenue
ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02755	
G-623		72 02755		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) M. Loretta Geraghty		2. DATE AND HOUR OF DEATH 3-17-72 7:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 903		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		E. STREET AND NUMBER 3606 Monterey Road			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-03	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transfer Agent		10B. KIND OF BUSINESS OR INDUSTRY Stock		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael J. Geraghty		14. MOTHER'S MAIDEN NAME Mary E. Reilly	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-0582		17. INFORMANT Mrs. Kathleen G. Heckrotte	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCUP 2 coronary artery disease severe 10 yrs		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 19 56 to Mar. 19 72, that (I) (we) last saw the deceased alive on Jan. 25 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Kammer, Jr.				23B. DATE SIGNED 20 Mar. 1972	
23C. PHYSICIAN'S NAME (Type) William H. Kammer, Jr. M. D.		23D. ADDRESS 6011 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Maryland 21212			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02756

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)/Parker
Margaret Shaver2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

3

16

72

8:25 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

823 Beaumont Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

3

16

72

8:25 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2713

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

12/16/1896

10. AGE (In years
last birthday)

75

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

5510 Roland Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edwin L. Parker

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Vari-type Operator Balto. Health Dept. Clara Shryver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

213-02-4577

18. INFORMANT

ADDRESS

Mrs. Nancy J. Hebb, Belair, Md.

19.

157.0

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Carcinoma of head of pancreas
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Partial

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-17-72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/20/72

24C. NAME of CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county) (State)

Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 20 1972

25B. NAME OF REGISTRAR

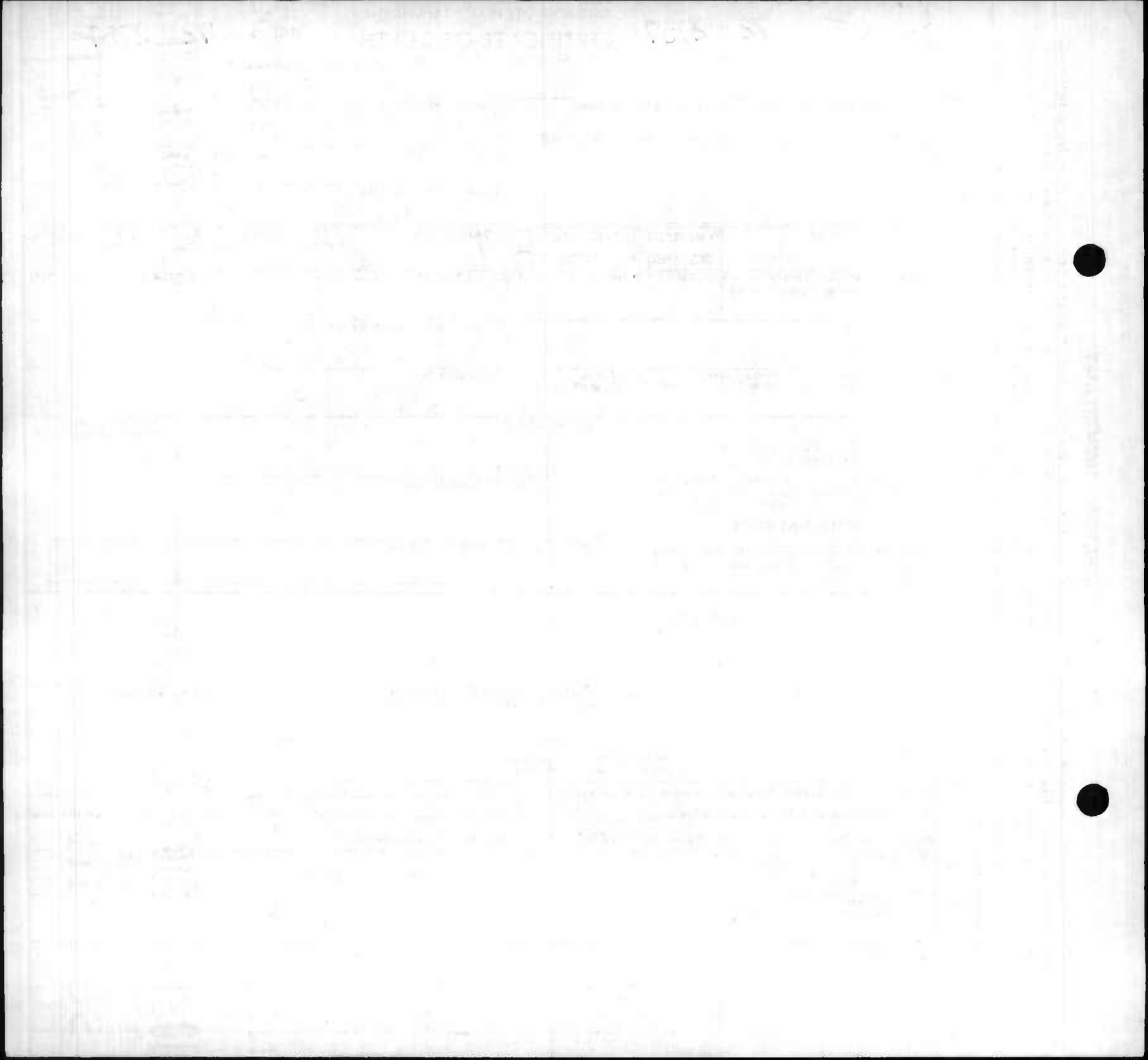
Robert E. [Signature]

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Balto., Md. 21212

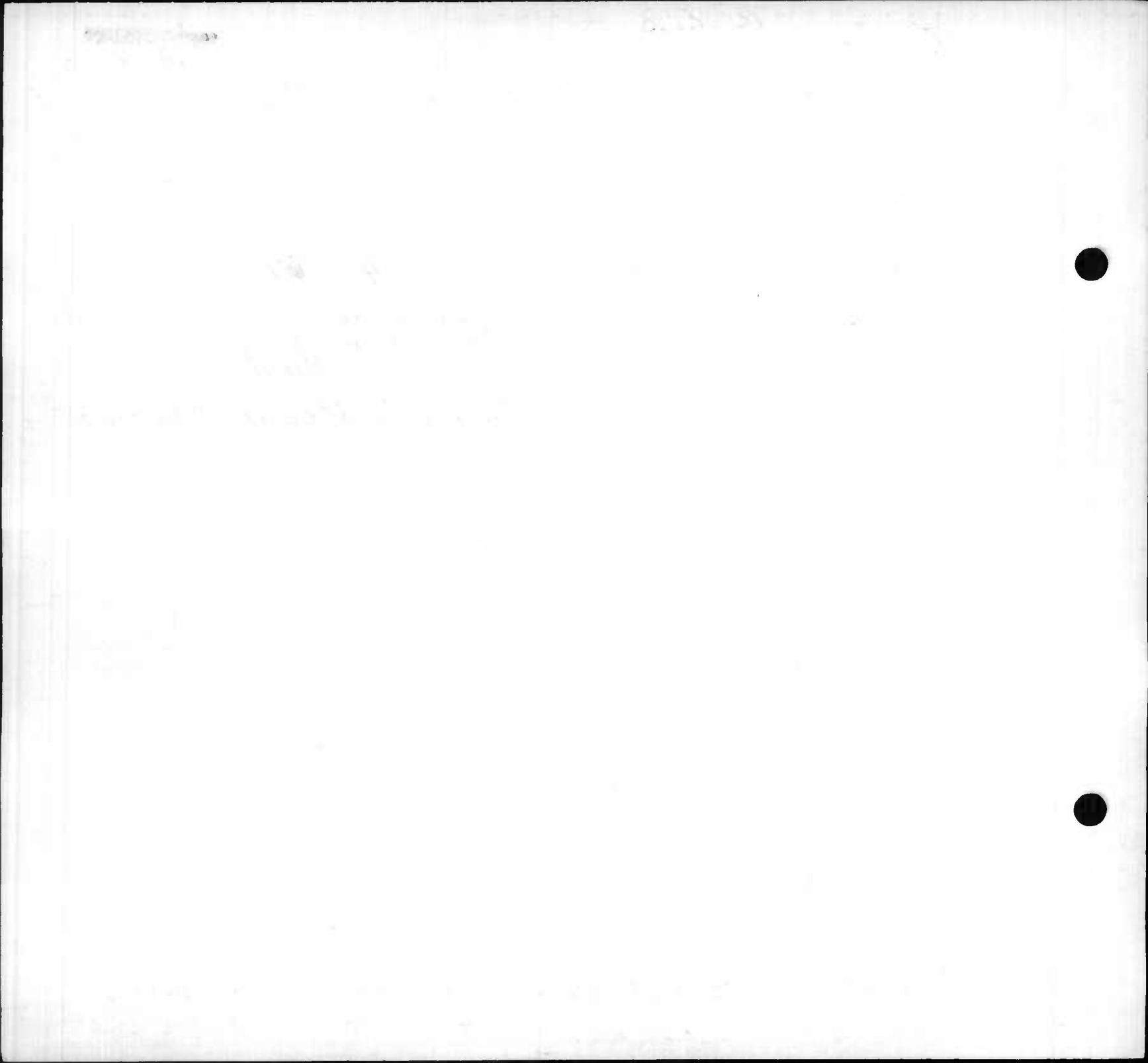
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death); and (6) No physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician who pronounced death was in regular attendance on the deceased prior to death). Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

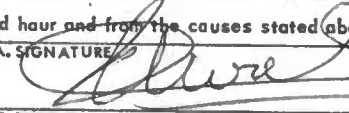


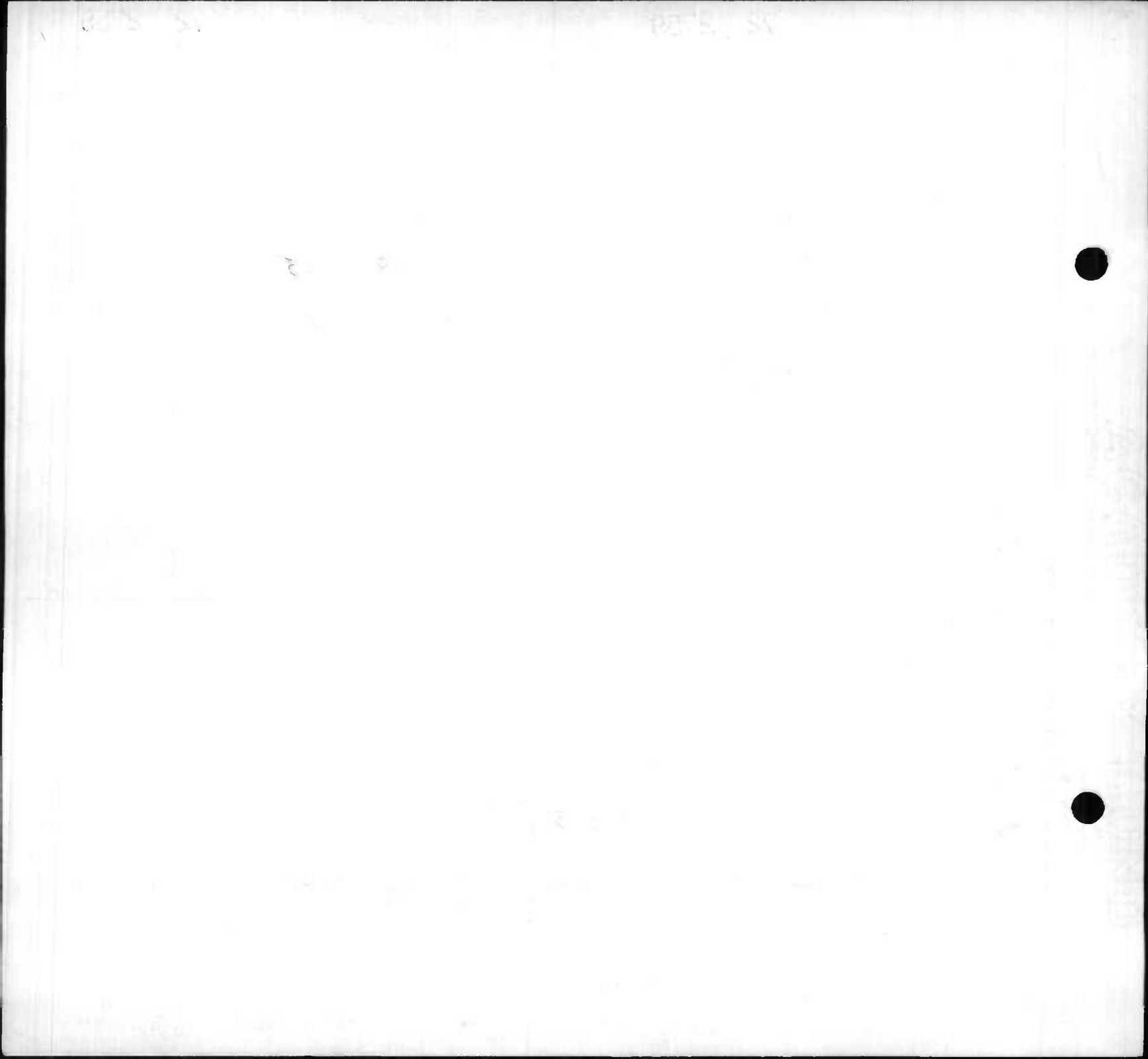
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02758</p>	
<p>BIRTH NO. H-430</p>		<p>72 02758</p>	
<p>1. NAME OF DECEASED (Type or Print) Holt, Mrs. Claretta A. Dorsey</p>		<p>2. DATE AND HOUR OF DEATH 3/16/72 10:00 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 3 + Bon Secours Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1604</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER 1933 Lauretta Avenue</p>			
<p>5. SEX Female</p>	<p>6. RACE B</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 3/27/04</p>
<p>9. AGE (In years last birthday) 67</p>		<p>10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Retired</p>	<p>11. BIRTHPLACE (State or foreign country) Unknown</p>
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		<p>13. FATHER'S NAME William Cole</p>	
<p>14. MOTHER'S MAIDEN NAME Theodora Lee</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>	
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Theodora McBane</p>	
<p>18. CAUSE OF DEATH 599.01</p>		<p>19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Abdominal Wall abscess more than 4 days.</p>	
<p>20. ANTECEDENT CAUSES Urinary tract infection more than 4 days.</p>		<p>21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 3/16/72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 3/12/72 19 to 3/16/72 19 that (I) (we) last saw the deceased alive on 3/16/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Yun Yong Yun</p>		<p>23B. DATE SIGNED 3/16/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) YUNYONG YUNYONGYING</p>		<p>23D. ADDRESS Bon Secours Hospital</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3-21-72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p>		<p>25B. NAME OF REGISTRAR</p>	
<p>25C. FUNERAL DIRECTOR MORTON AND DYETT</p>		<p>ADDRESS 1701 Laurens Street (21217)</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-255		72 02759		BALTIMORE CITY HEALTH DEPARTMENT		72 02759	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CARSON BUCHANAN				2. DATE AND HOUR OF DEATH MARCH 16th 1972 2:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL OF BALTIMORE INC.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE INC.				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3216 MILFORD MILL Rd. #7							
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/06	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) Jackson Springs, NC	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME Mack Buchanan				14. MOTHER'S MAIDEN NAME Mary Buchanan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-01-7322		17. INFORMANT Elizabeth Buchanan ADDRESS -3216-Milford Ave	
18. 197.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF: 12 days				(A) IMMEDIATE CAUSE HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF: 12 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF THE LIVER DUE TO, OR AS A CONSEQUENCE OF: 2 months				(B) CARCINOMA OF THE LIVER DUE TO, OR AS A CONSEQUENCE OF: 2 months			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/15/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LIVER BIOPSY		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/13/72 19 to 3/15/72 19 that (I) (we) last saw the deceased alive on 3/15/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				H.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/16/72	
23C. PHYSICIAN'S NAME (Type) DANIEL W. HIRELMAN M.D.				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-72		24C. NAME OF CEMETERY OR CREMATORY Garden of Eternal Life Finksbury, Md		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR MORTON & DYETT		ADDRESS 1701 Laurens St. Baltimore, Maryland 21217	



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHNNY COOPER

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 19, 1972

2:30 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

906

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10/29/27

10. AGE (In years last birthday)

45

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1820 E. 30th Street

11. BIRTHPLACE (State or foreign country)

Florence S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Aldolphus Cooper

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Steel Worker

14B. KIND OF BUSINESS OR INDUSTRY

Steel

15. MOTHER'S MAIDEN NAME

Ophelia Moses

1826 N. Caroline St.

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

248-32-5243

18. INFORMANT

ADDRESS

Frances Gibson 1941 E. 31st. Street

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Stab wound of back

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

3963 Wilsby Avenue

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

3-19-72

2:15 A.m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/19/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/23/72

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State)

Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 20 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

William J. Spicer

ADDRESS

1639 N. Broadway Balt Md.

QTS-51

0808-55

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

WILLIAM FORD

25/00000000

X

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

72 02761

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02761

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LILLIAN JONES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 16, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1031 East Biddle Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 16, 1972 12:05 P.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12/27/1910		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 63		E. STREET AND NUMBER 1031 East Biddle Street	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Henderson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Florence Carey		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Lorraine Batson 3834 Cottage Ave. Balt. Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Aortic stenosis and insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22G. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22H. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		DATE SIGNED March 16, 1972	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR William J. Spicer	
25C. FUNERAL DIRECTOR William J. Spicer		ADDRESS 1639 N. Broadway	

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

VALLEY

...

38-62-66 JD

Released On Approval By Medical Examiner

Real

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-620		72 02762		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02762	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>John George Gorge</u>				2. DATE AND HOUR OF DEATH <u>3-18-72</u> <u>7:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2611</u>			
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1111 S. Bouldin St. 21224</u>							
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-13-05</u>	9. AGE On years last birthday <u>66</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Cont. Can. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William</u>				14. MOTHER'S MAIDEN NAME <u>Mattie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-03-4197</u>		17. INFORMANT <u>4940 Eastern Ave.</u> <u>BCH Records: Baltimore, Md. 21224</u>	
18. <u>4-12-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Anterior</u> CHIEF OR MOST IMPORTANT MEDICAL EXAMINER DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Anterior</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>1 day</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>3-18-1972</u> to <u>3-18-1972</u> that (1) (we) last saw the deceased alive on <u>3/18</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Kevin J. Hunt</u> DEGREE						23B. DATE SIGNED <u>3-18-72</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-22-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. 200</u>		25C. FUNERAL DIRECTOR <u>Thelma J. Hoffman</u>		ADDRESS <u>3218 Hudson St.</u>	

72 02763

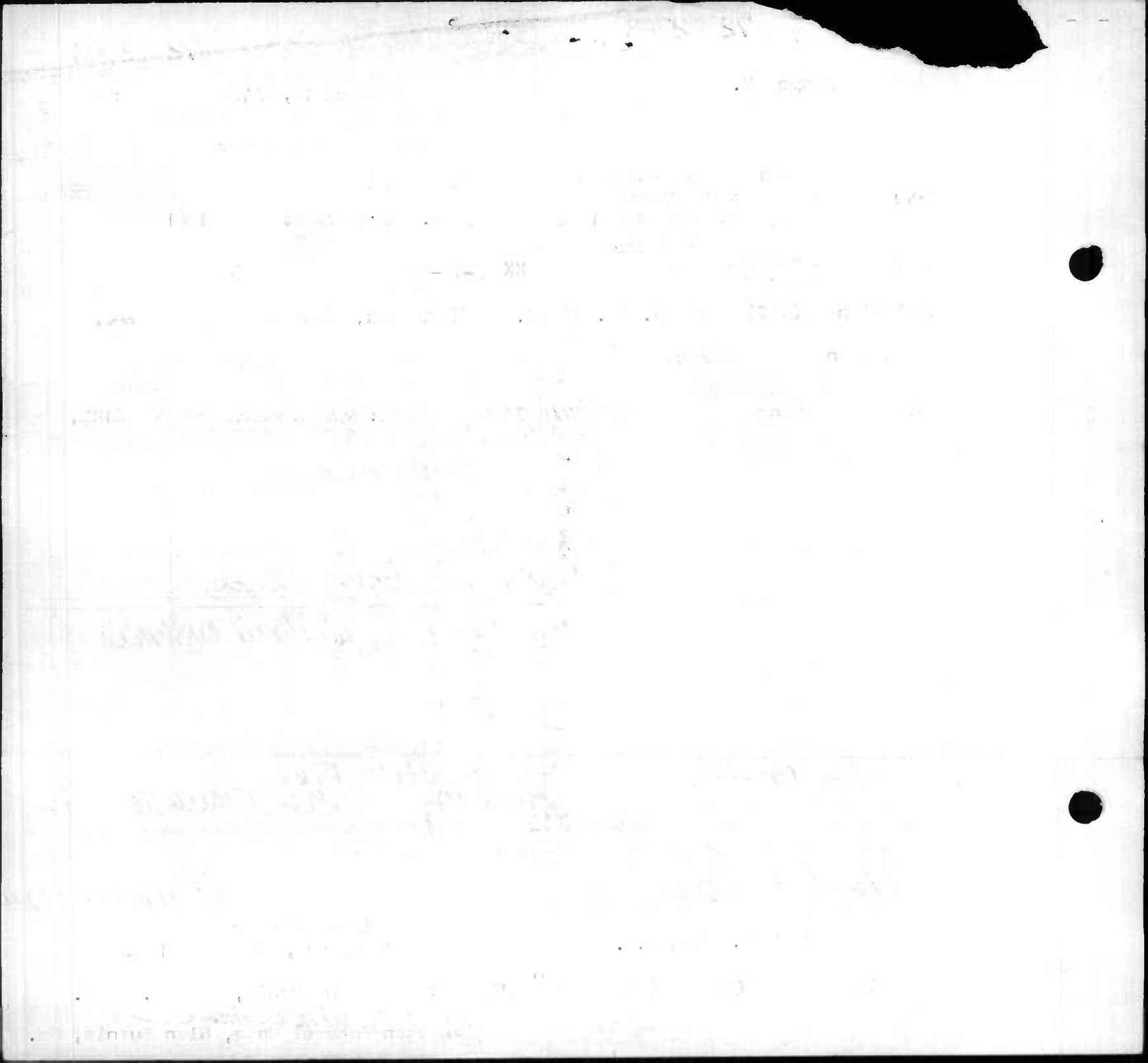
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02763

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decedent was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) Jesse N. Wallace		2. DATE AND HOUR OF DEATH March 16, 1972 6:00 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Anne Arundel 5200	
5. SEX Male		6. RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-18-08	
9. AGE (In years last birthday) 63		10. If Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) Flat Rock, Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sherman Wallace		14. MOTHER'S MAIDEN NAME Ada McGee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. INFORMANT BCH RECORDS: 4940 Eastern Avenue 21224	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia Septic 30% 3rd degree burn		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CHIEF OR ASSOCIATED CAUSE OF DEATH DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Renal failure, alcoholic cirrhosis			
19. DATE OF OPERATION Jan 17, 1972		20. CONDITION FOR WHICH OPERATION WAS PERFORMED Stave Fire	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5 St Agnes St., Glen Burnie		21D. TIME OF INJURY (APPROX.) Jan 17, 1972	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Stave Fire	
22. I certify that (I) (this hospital) attended the deceased from Jan 17 19 72 and that (my) (our) opinion death occurred on the date March 16 19 72 and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David K. Bone		23B. DATE SIGNED March 16, 1972	
23C. PHYSICIAN'S NAME (Type) David K. Bone, M.D.		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/72	
24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Singleton Funeral Home		25D. ADDRESS Glen Burnie, Md.	



C-430

72 02764 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02764

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HAROLD E. CLOUDE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour March 17, 1972 8:09 P.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2653							
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5-25-24		10. AGE (In years lost birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 5056 Orville Avenue			
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William C. Cloude			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		14B. KIND OF BUSINESS OR INDUSTRY Monarch Rubber Co.		15. MOTHER'S MAIDEN NAME Aprie E. Richards			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 230 24 2789		18. INFORMANT ADDRESS Lucy G.G. Cloude 5056 Orville Avenue Balto 5			
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/18/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-72		24C. NAME of CEMETERY or CREMATORY Mt. Zion		24D. LOCATION (City, town, or county) (State) Luray, Page, Co. Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR <i>Robert E. Jones, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Philip E. Coach</i> 1221 Chesaco Ave.			

x

Virginia

Thomas

for

W. H.

Department of Health and Human Services

WALTER ROY

WALTER ROY

Large, Paper, Co. Virginia

Mr. Dixon

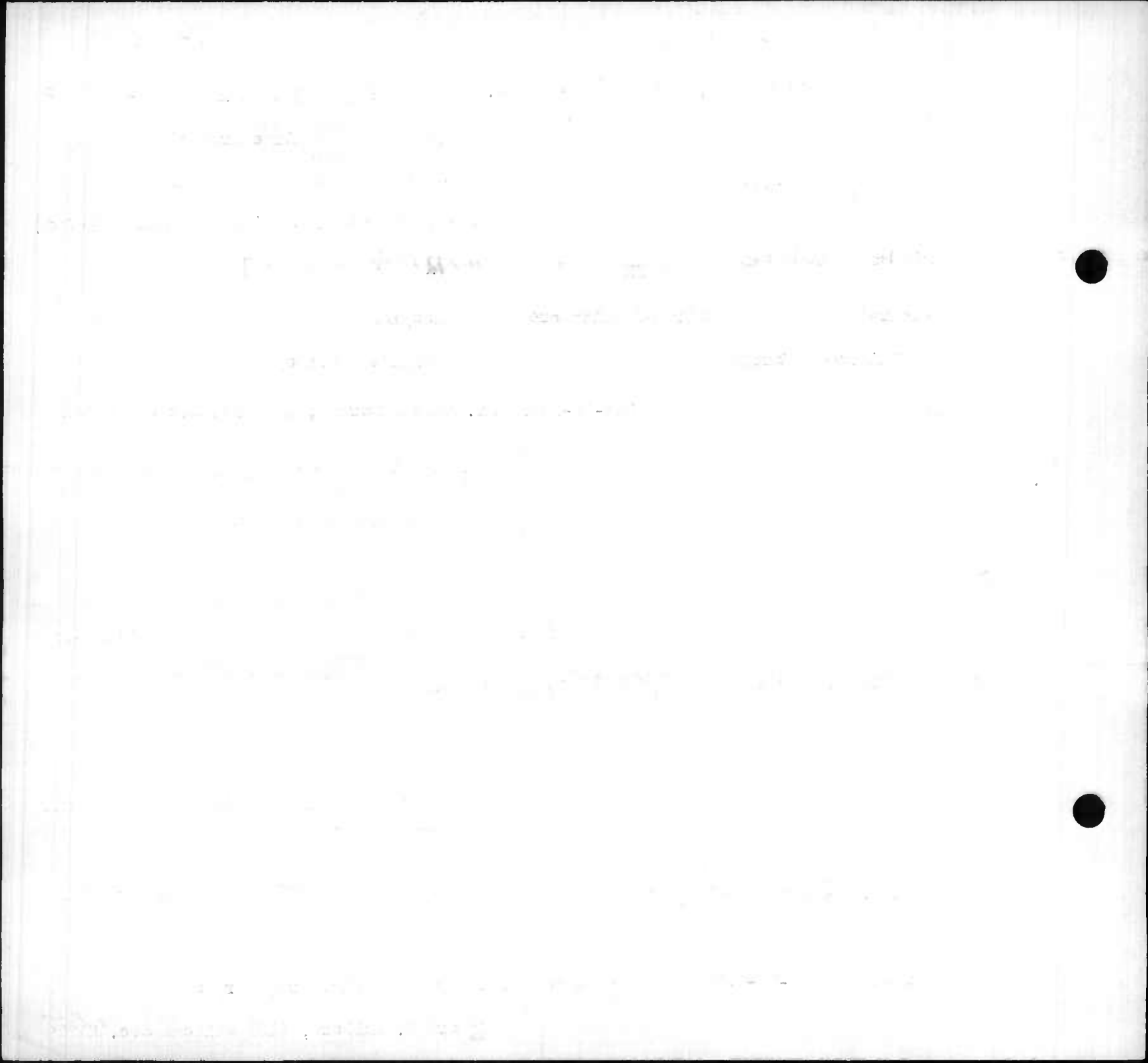
Small

II II

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02765	
M-635 72 02765		CERTIFICATE OF DEATH	
BIRTH NO. 11-635		2. DATE AND HOUR OF DEATH 3 / 17 / 72 6:15 P.M.	
1. NAME OF DECEASED (Type or Print) MARTIN, EDWARD E.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSP.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE M.D. B. COUNTY Anne Arundel 5200	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1007 - 5th. St. Glenburnie, 21061	
5. SEX Male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY City Of Baltimore	9. AGE (In years last birthday) 67 If Under 1 Yr. Months: Days: Hours: Min.
13. FATHER'S NAME William Martin		11. BIRTHPLACE (State or foreign country) Maryland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 214-03-5869		14. MOTHER'S MAIDEN NAME Minnie Colway	
17. INFORMANT Mr. Edmund Martin, 1007 5th Avenue 21061		ADDRESS	
18. 136 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Broncho pneumonia, pseudomonas infection.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Septicemia.		7 days	
19A. DATE OF OPERATION 2/24/72, 2/25/72, 2/26/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Splenectomy, Aorto femoral bypass, post op bleeding	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb. 10 1972 to Mar. 17 1972 that (I) (we) last saw the deceased alive on Mar. 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jakro Sig...		23B. DATE SIGNED Mar. 17 72	
23C. PHYSICIAN'S NAME (Type) Robert E. Fisher, M.D.		23D. ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-1972	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02766
1. NAME OF DECEASED (Type or Print) LOCKWICH, PETE K. (ALSO PETE K. LEKAVICIUS)		2. DATE AND HOUR OF DEATH MARCH 17, 1972 4:15A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2102 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1326 GLYNDON AVE 21223		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09 15 88	9. AGE (in years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) LITHUANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CASPER LOCKWICH		
14. MOTHER'S MAIDEN NAME (KALUPAILA) FELICIA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 213091544		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerosis generalized II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary emphysema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from MARCH 17, 1972 to MARCH 17, 1972 that (X) (we) last saw the deceased alive on MARCH 17, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.		
23A. SIGNATURE P. Valarao		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) P VALARAO, M.D.
23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL: CATON & WILKENS AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3-20-1972		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229

(RECEIVED - 1964 - 10 - 10)

By ROBERT HARRIS

CHURCH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

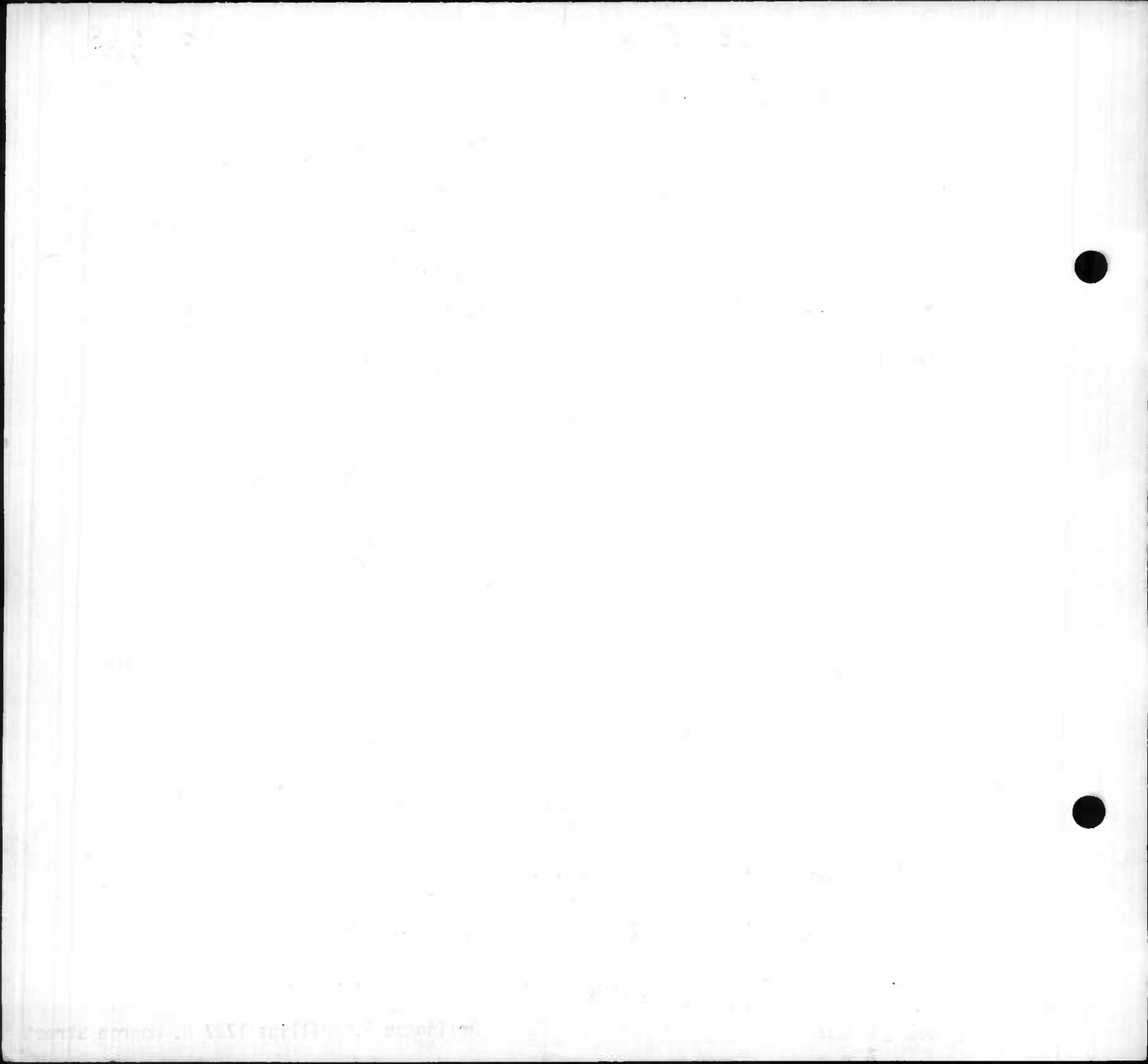
BIRTH NO. 7-422		72 02767		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02767	
1. NAME OF DECEASED (Type or Print) FULKUSKI KATHERINE E.				2. DATE AND HOUR OF DEATH 3.15.72 9:10 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1306			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3500 ELM AVENUE, BALTIMORE			
5. SEX F	6. RACE I W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11.23.83	9. AGE (In years last birthday) 88	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME MICHAEL LYNCH.			
14. MOTHER'S MAIDEN NAME ALDRIDGE				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -			
16. SOCIAL SECURITY NO. 216-74-0601				17. INFORMANT Mrs Geraldine Snyder Pno: 235-1976			
18. 3-74-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cholelithiasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cholelithiasis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cholelithiasis (B) Cholelithiasis DUE TO, OR AS A CONSEQUENCE OF: Cholelithiasis (C) Cholelithiasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-20-72 to 3-15-72	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3.9.72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-20-72 to 3-15-72 , that (I) (we) last saw the deceased alive on 3-15-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. J. Unanue				23B. DATE SIGNED 3.15.72			
23C. PHYSICIAN'S NAME (Type) L. J. Unanue				23D. ADDRESS Calvert + 33rd St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-72		24C. NAME of CEMETERY or CREMATORY Landon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR W. S. S. S.		25C. FUNERAL DIRECTOR Frank W. S. S.		25D. ADDRESS 814 W. 36th St.	

1933-7-30

في يوم الثلاثاء ١٠ من شهر ربيع الثاني ١٣٥٢

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-300		72 02768		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02768	
1. NAME OF DECEASED (Type or Print) Roland Reid				2. DATE AND HOUR OF DEATH Mar 13, 1972 1:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL Hosp				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1303			
				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2485 Druid Hill Ave #17			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/06	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Major Reid				14. MOTHER'S MAIDEN NAME Sarah Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-02-0225		17. INFORMANT Robert J Doub		ADDRESS 1100 Cathedral	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
				(B) ACUTE ANTERIOR MYOCARDIAL DUE TO, OR AS A CONSEQUENCE OF: INFARCTION			
				(C) ARTERIO-SCLEROTIC CVD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? N/A		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? N/A			
22. I certify that (I) (this hospital) attended the deceased from Mar 13 1972 to Mar 13 1972 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ann R Wilke				23B. DATE SIGNED 3/14/72		23C. PHYSICIAN'S NAME (Type) Ann R Wilke	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-17-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02769

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PERCY LEE PERRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1916 W. Baltimore St.		3. DATE PRONOUNCED DEAD Month Day Year Hour March 15. 1972 9:25 P M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 54 DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2001	
9. DATE OF BIRTH 12-7-26		10. AGE (In years lost birthday) 45	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter Perry		14. MOTHER'S MAIDEN NAME Nella Trotman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 325-28-9090	
17. INFORMANT Martha P. Perry		18. ADDRESS Same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 16, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 3-20-72	
24C. NAME OF CEMETERY or CREMATORY Cross Cemetery		24D. LOCATION (City, town, or county) (State) Franklin U.A.	
25A. DATE REC'D BY HEALTH DEPT. MAR 20 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR W. H. Phillips		ADDRESS 1727 N. Mount St.	

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

1888

W-520

72 02770

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02770

BIRTH NO. 66-13276

REG. NO.

1. NAME OF DECEASED (Type or Print) TARTIA WEEMS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year March 17, 1972 Hour 9:15 P.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6-28-66		10. AGE (In years last birthday) 5 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Rosalyn Evans		18. INFORMANT ADDRESS	

MEDICAL CERTIFICATION	19. E911X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Asphyxia	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
	(B) Aspiration of bolus of food DUE TO, OR AS A CONSEQUENCE OF:			
	(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4509 Fairfax Road 4525 2843
22D. TIME OF INJURY (APPROX.) 3-17-72 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Choked while eating

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) DATE SIGNED **3/18/72**
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-21-72	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Ronald N. Kornblum	25C. FUNERAL DIRECTOR, ADDRESS Bureau of Health 2700 Edmondson Ave

0.88 57

0.88 57

2024

2024

2024

2024

2024

2024

2024

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-360 72 02771				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02771	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>Potter, Edna D.</u>				2. DATE AND HOUR OF DEATH <u>3/20/72</u> <u>5:00</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Balto.</u> B. COUNTY <u>21214</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3209 E Northern PKWY 2745</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/11/91</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Mo. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard L. Denton</u>				14. MOTHER'S MAIDEN NAME <u>Phoebe ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-03-9377</u>		17. INFORMANT ADDRESS <u>Mrs. Edith Bailowe Same</u>	
18. <u>560,911</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Heart Failure; Possible Pulmonary Embolism</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal Failure</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Intestinal Obstruction</u> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>1/3/18/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal Obstruction</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>3/19</u> 19 <u>72</u> to <u>5 AM</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>3/20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Willard P. Amoss M.D.</u>				23B. DATE SIGNED <u>3/20/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Willard P. Amoss M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/23/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. 5305 Harford Rd</u>			

Northwestern

18

19

W

Northwestern

Northwestern

Northwestern

Northwestern

2/10

MD

Northwestern

Northwestern

Northwestern

S-163

72 02772

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02772

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAUDE A. SEIFERT Seifert				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 19 1972 7:40p			
6. SEX female		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2641	
9. DATE OF BIRTH Aug. 7, 1884		10. AGE (In years lost birthday) 87		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		148. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME August Moessinger		15. MOTHER'S MAIDEN NAME Belinda (unknown)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-01-6348		18. INFORMANT ADDRESS Mr Ira H Moessinger 503 Dorsey Ave. 21221			
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute bronchopneumonia secondary to arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 3-20-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-72		24C. NAME of CEMETERY or CREMATORY Western Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Balto. Md. 21214			

- **Art 18**

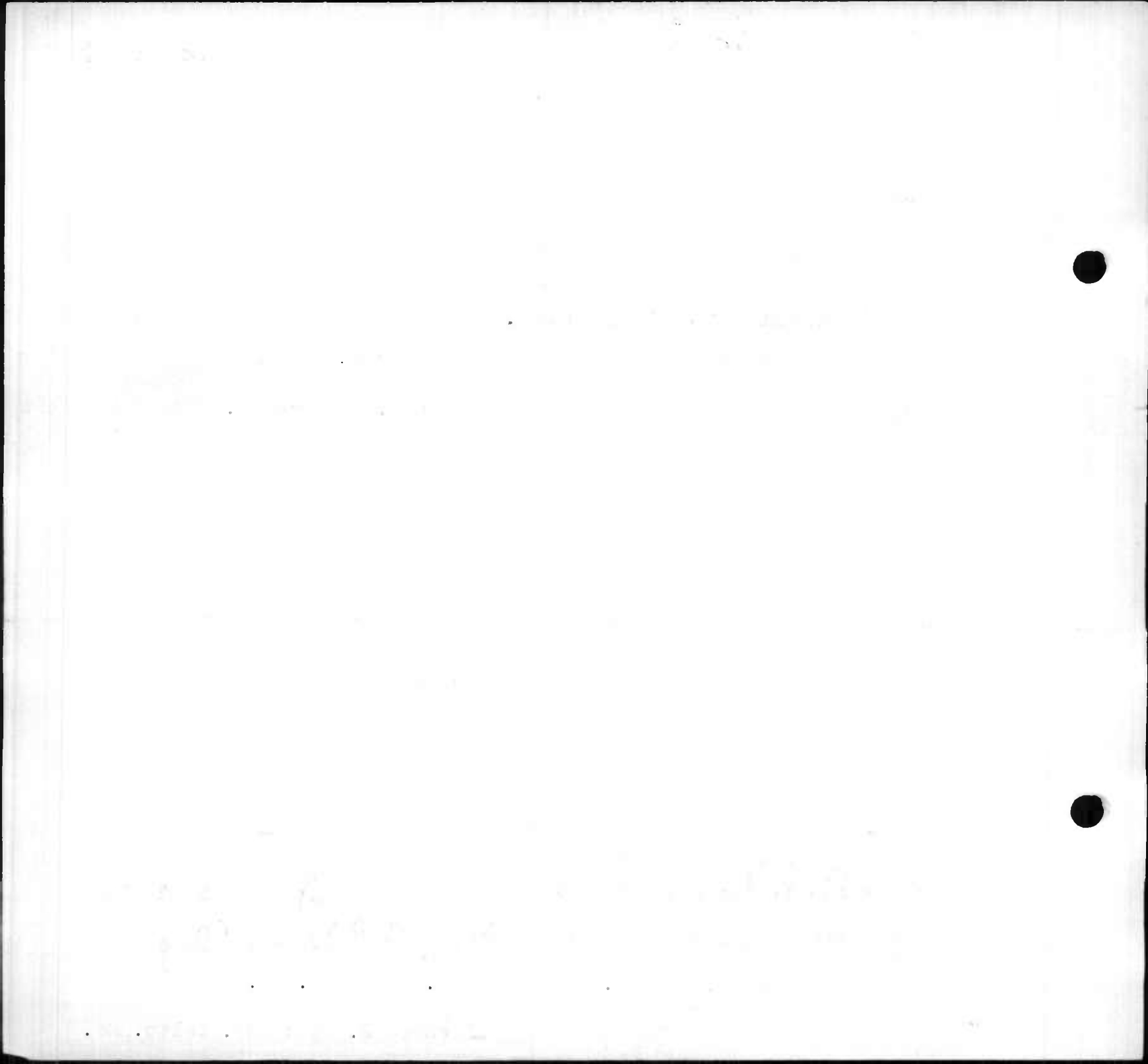
64

• 5M • of Ltd

55-15-1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 171768



72 02774

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02774

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) L. LAWRENCE KING		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 3901 Wilke Avenue (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 18, 1972 1:10 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2741	
9. DATE OF BIRTH 6/3/1913		10. AGE (In years last birthday) 58	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. 214-01-8118	
15. MOTHER'S MAIDEN NAME Lena		18. INFORMANT ADDRESS 8 Mrs. Sophie King same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 3/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/72	
24C. NAME OF CEMETERY or CREMATORY Meadow Ridge		24D. LOCATION (City, town, or county) (State) Dorsey, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		ADDRESS	

75 5 3

WALLING FOLIO
COLUMBIAN COLLEGE

Library, etc.

London place

Waller

Chief

W. L. Walling

1875

W. L. Walling

W. L. Walling

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		72 02775		BALTIMORE CITY HEALTH DEPARTMENT		72 02775	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Elizabeth C. Beran				March 18, 1972 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00				A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3010 Clearview Ave.				B. COUNTY 2735			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3010 Clearview Ave.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 6, 1924	9. AGE (In years last birthday) 48	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Freeburger				14. MOTHER'S MAIDEN NAME Mary Anne Ellwood			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-22-8766		17. INFORMANT Albert W. Beran		ADDRESS same	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma, Bronchogenic		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10 May 1972 to 18 March 1972 that (I) (we) last saw the deceased alive on 16 March 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edward L. Molz M.D.				23B. DATE SIGNED 20 March 72			
23C. PHYSICIAN'S NAME (Type) Edward L. Molz				23D. ADDRESS 7425 Harford Road Baltimore, Md. 21234			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/1972		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Chas. F. Evans & Son		ADDRESS 8802 Harford Rd.	

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some fragments are visible, such as "The following information was obtained from..." and "The following information was obtained from..." in the upper left, and "The following information was obtained from..." in the lower right.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 02776		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Bertha E. Miller BERTHA MILLER				2. DATE AND HOUR OF DEATH 3/17/72 2:20 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GENERAL HOSPITAL North Charles General Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Sparrows Point D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1332 Forest Road					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-83		9. AGE (In years last birthday) 88 88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ETHA THONSTOWN, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gouchnour				14. MOTHER'S MAIDEN NAME Mariah Wlaters					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-30-6912		17. INFORMANT Daughter: 1332 Forest Road Mrs. Lois Reighard Sparrows Point, Md. 21219			
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) germinal arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: with chronic brain syndrome (C) leucemia anemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/11 19 72 to 3/17 19 72 that (I) (we) lost saw the deceased alive on 3/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Veena Sathirakul M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/17/72			
23C. PHYSICIAN'S NAME (Type) VEENA SATHIRAKUL				23D. ADDRESS NORTH CHARLES GEN HOSP					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-21-72		24C. NAME OF CEMETERY or CREMATORY Headricks Cemetery		24D. LOCATION (City, town, or county) (State) Johnstown, Pennsylvania			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Blue E. Miller, M.D.		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			

22

21-1-11

1914

11

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02777	
<div style="display: flex; justify-content: space-between;"> L-220 72 02777 X </div>					
BIRTH NO. 72 02777					
1. NAME OF DECEASED (Type or Print) Sophie Lejsiak			2. DATE AND HOUR OF DEATH 3/16/72 6:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 2317 Ruth Ave.			2317 Ruth Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/97	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Lewczak		
14. MOTHER'S MAIDEN NAME Mary			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-07-3038HE			17. INFORMANT Husband: Mr. James L. Lejsiak ADDRESS 2317 Ruth Avenue Balto. Md. 21219		
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE Sepsis DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Chronic Brain Syndrome and DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Cerebral Vascular Accident</p> </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2/		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Ross Davidson Jr. M.D.				23B. DATE SIGNED 3/16/72	
23C. PHYSICIAN'S NAME (Type) William Ross Davidson M.D.				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 20, 1972		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary Cem. Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.	

06/10

47

19/11/11

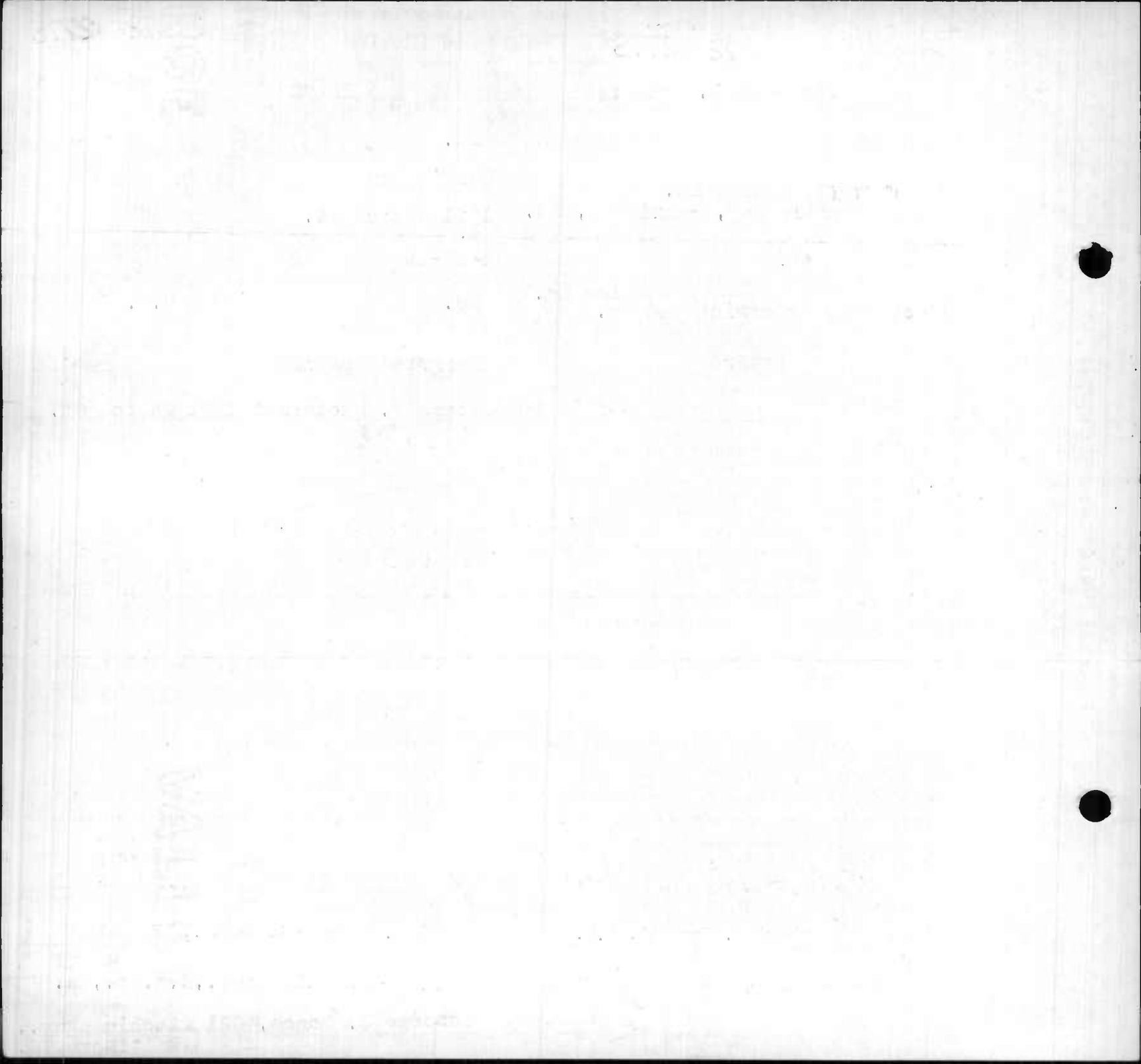
ABH

diary

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02778</u>
BIRTH NO. <u>S-346</u>		72 02778 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Florence M. Stolarski</u>		2. DATE AND HOUR OF DEATH <u>3 16 72</u> <u>10:00</u> <u>A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1301 Church St.</u> <u>Curtis Bay, Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2505</u> C. CITY OR TOWN <u>Curtis Bay</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1301 Church St.</u>		
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-10</u>	9. AGE (In years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Lady McCormick and Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Spice Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Bayard</u>		
14. MOTHER'S MAIDEN NAME <u>Margaret Meekins</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>215 05 6821</u>		17. INFORMANT <u>Thomas T. Stolarski 1301 Church St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Asphyxia 2° Brain metastases</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Undifferentiated Carcinoma of</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>the ovary</u> (C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert M. Barnett M.D.</u>				23B. DATE SIGNED <u>17 March 72</u>
23C. PHYSICIAN'S NAME (Type) <u>Robert M. Barnett, M.D.</u>		23D. ADDRESS <u>3001 S. Hanover St. Balto., Md. 21230</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3 20 72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Ritchie Hgwy., A.A. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		
25B. NAME OF REGISTRAR <u>George J. Gonce</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce, 4001 Ritchie Hgwy., Baltimore, Md.</u>		



72 02779

BALTIMORE CITY HEALTH DEPARTMENT

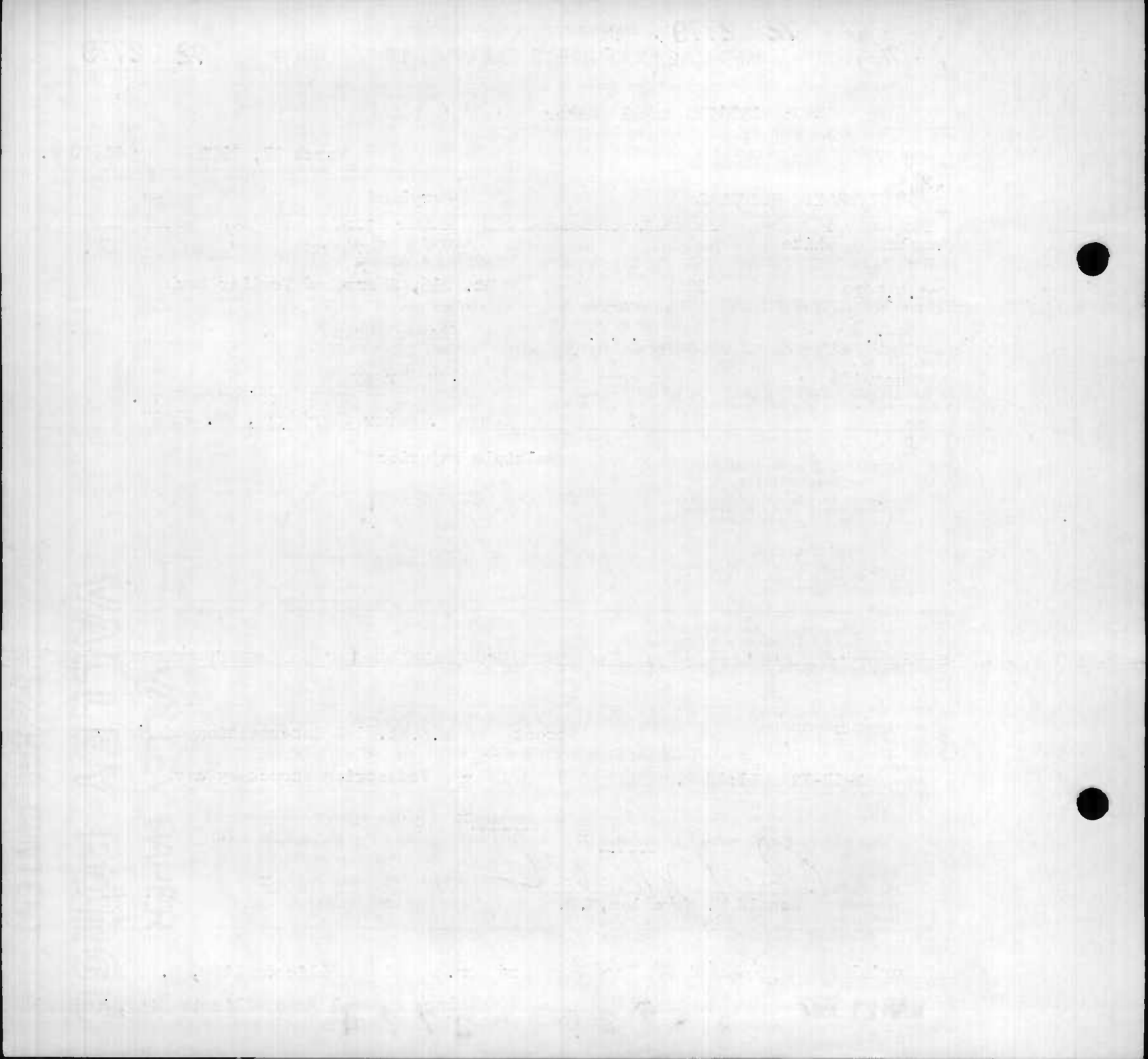
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02779
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GRACE DASHER Jewell Dasher		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 17, 1972 12:00 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard 6300	
9. DATE OF BIRTH Oct. 7, 1919		10. AGE (In years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY at home	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. ?	
15. MOTHER'S MAIDEN NAME Ellen Purkey		18. INFORMANT 9708 Washington Street John E. Dasher Elkridge, Md. 21227	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Multiple Injuries (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Multiple Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) U.S. Rt. #1 & Intersection of Sherwood Drive 6300	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-17-72 11:15 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by car	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/18/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/72		24C. NAME of CEMETERY or CREMATORY Good Shepherd Cem.	
24D. LOCATION (City, town, or county) (State) Ellicott City, Md.		24E. DATE REC'D BY HEALTH DEPT. MAR 21 1972		24F. NAME OF REGISTRAR Robert E. Galt	
24G. FUNERAL DIRECTOR Slack Funeral Home, Ellicott City, Md 21043		24H. ADDRESS		24I. 72 02779	



72 02780 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02780

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT PAYTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour March 18, 1972 12:10 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 26, 1929	10. AGE (In years last birthday) 42	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Alexander Payton	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective		15. MOTHER'S MAIDEN NAME Charlotte Campbell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		17. SOCIAL SECURITY NO. 212-26-1062	
18. INFORMANT Laura J. Payton (Wife)		ADDRESS 21225 324 Church St., Balto.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 0		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type)		DATE SIGNED 3/18/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/22/72	24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	24D. LOCATION (City, town, or county) (State) Anne Arundel Co.; Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS Mc Cully, H. 237 Patapsco Ave., Balto. 21225	

75 57

75 57

three hundred

x

June 2, 1929

Chicago, Illinois

U.S.A.

England

Charlotte Campbell

Law Enforcement

Detective

112-1102 James J. Patton (Wife) (James J. Patton)

See known

James J. Patton (Wife) (James J. Patton)

WILLIAM

WILLIAM

three hundred (a) (b) (c)

John Hill (a) (b) (c)

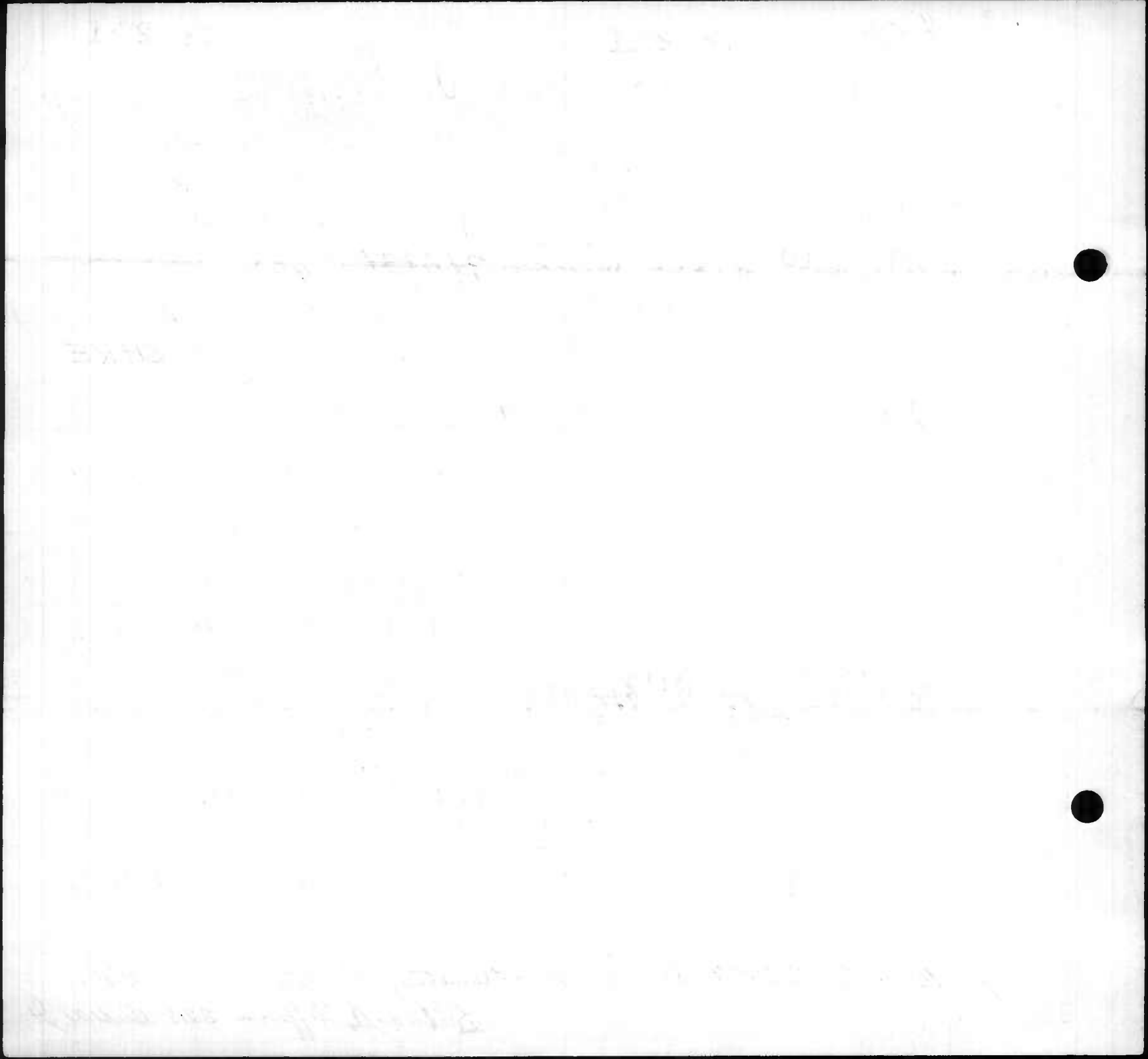
1/20/29

Serial

Copyright © 1929 William J. Patton

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02781	
72 02781 CERTIFICATE OF DEATH					
BIRTH NO. 4-545		1. NAME OF DECEASED (Type or Print) HAMMELMAN PAUL J.		2. DATE AND HOUR OF DEATH 3/19/72 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 21 21224 101		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME Hosp BALTO MD 21231			5. CITY OR TOWN BALTIMORE		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 7/6/31 9. AGE (in years last birthday) 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10A. KIND OF BUSINESS OR INDUSTRY Cook
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY AMERICAN		
13. FATHER'S NAME HARRY HAMMELMAN			14. MOTHER'S MAIDEN NAME ELIZABETH TRUSHKE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 216 24 2621		17. INFORMANT Dr. Mehl CH-H.
18. 532.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE CARDIAC ARREST 1 hour.		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) POSSIBLE PULMONARY EMBOLUS 4 hours.		
			(C) POST-OP. BLEEDING D. V. 8 days.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			GEMILEMIA ANATOMOTIC LEAK 3 days.		
19A. DATE OF OPERATION 3/12/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING P-V		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/11/72 to 3/19/72 that (I) (we) last saw the deceased alive on 3/19/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A Mehl MD			23B. DATE SIGNED 3/19/72		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Dr. Ashwin MEHTA MD			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-72		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery Balto.	
24D. LOCATION (City, town, or county) MD.		24E. (State)		24F. (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Miller		25C. FUNERAL DIRECTOR William R. Hoffmann 3218 Hudson St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 7-300 72 02782 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 02782	
BIRTH NO. 7-300		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 3 19 72 7:15 A.M. </div>	
1. NAME OF DECEASED (Type or Print) FOOTE, FLORENCE M.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 45 THE GOOD SAMARITAN HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1216 HOMERWOOD AVE. 21202	
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-06-89
9. AGE (in years last birthday) 84		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chas. Johnson		14. MOTHER'S MAIDEN NAME Sophie ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-18-0219	
17. INFORMANT Carrie Causion		ADDRESS 1216 Homewood Ave	
18. 268 X I CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
(A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: IMMEDIATE			
(B) MULTIPLE DEATH DUE TO, OR AS A CONSEQUENCE OF: 19X			
(C) CANCER 1XR			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William A. Carter, M.D.		23B. DATE SIGNED 3-19-72	
23C. PHYSICIAN'S NAME (Type) WILLIAM A. CARTER, M.D.		23D. ADDRESS THE GOOD SAMARITAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72	
24C. NAME OF CEMETERY OR CREMATORY Dawson Cemetery		24D. LOCATION (City, town, or county) (State) Cockeysville, Balt. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR Christina Jones		ADDRESS 1701 McCall St	

Page 1 of 1

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02783		72 02783	
T-460		72 02783		72 02783	
BIRTH NO.		72 02783		72 02783	
1. NAME OF DECEASED (Type or Print) <i>Taylor, Elmer</i>		2. DATE AND HOUR OF DEATH <i>3/18/72</i> <i>11:00</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>HARFORD</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIV. MARYLAND Hosp.</i> <i>38</i>		C. CITY OR TOWN <i>Edgewood</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3602 Philadelphia Rd</i>			
5. SEX <i>M</i>	6. RACE <i>CAUC</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-27-32</i>	9. AGE (in years last birthday) <i>49</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lab. Mechanic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>US-Govt.</i>		11. BIRTHPLACE (State or foreign country) <i>Duty, Virginia</i>	
13. FATHER'S NAME <i>William Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Mary McFadden</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>230-12-9139</i>		17. INFORMANT <i>Mrs. Catherine Taylor, 2602 Phila Road, Edgewood, Md.</i>	
18. <i>162.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: <i>and brain stem damage 2° to exother</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>① Factor TX clothing deprivation</i> <i>② Boredom excessive 7 hrs</i>					
19A. DATE OF OPERATION <i>3/16</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of lung</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>3/14</i> 19 <i>72</i> to <i>3/18</i> 19 <i>72</i> that (I) (<i>we</i>) last saw the deceased alive on <i>3/18</i> 19 <i>72</i> and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>We</i>) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John R. Sattenfield MD</i>		23B. DATE SIGNED <i>3/18/72</i>		23C. PHYSICIAN'S NAME (Type) <i>John R. Sattenfield MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar. 22, 1972</i>		24C. NAME of CEMETERY or CREMATORY <i>Bel Air Memorial Gardens</i>	
24D. LOCATION <i>Bel Air</i>		24E. CITY, TOWN, or county <i>Harford</i>		24F. STATE <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 21 1972</i>		25B. NAME OF REGISTRAR <i>Howard K. McComas, III</i>		25C. FUNERAL DIRECTOR <i>Howard K. McComas, III, Abingdon, Md.</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02784

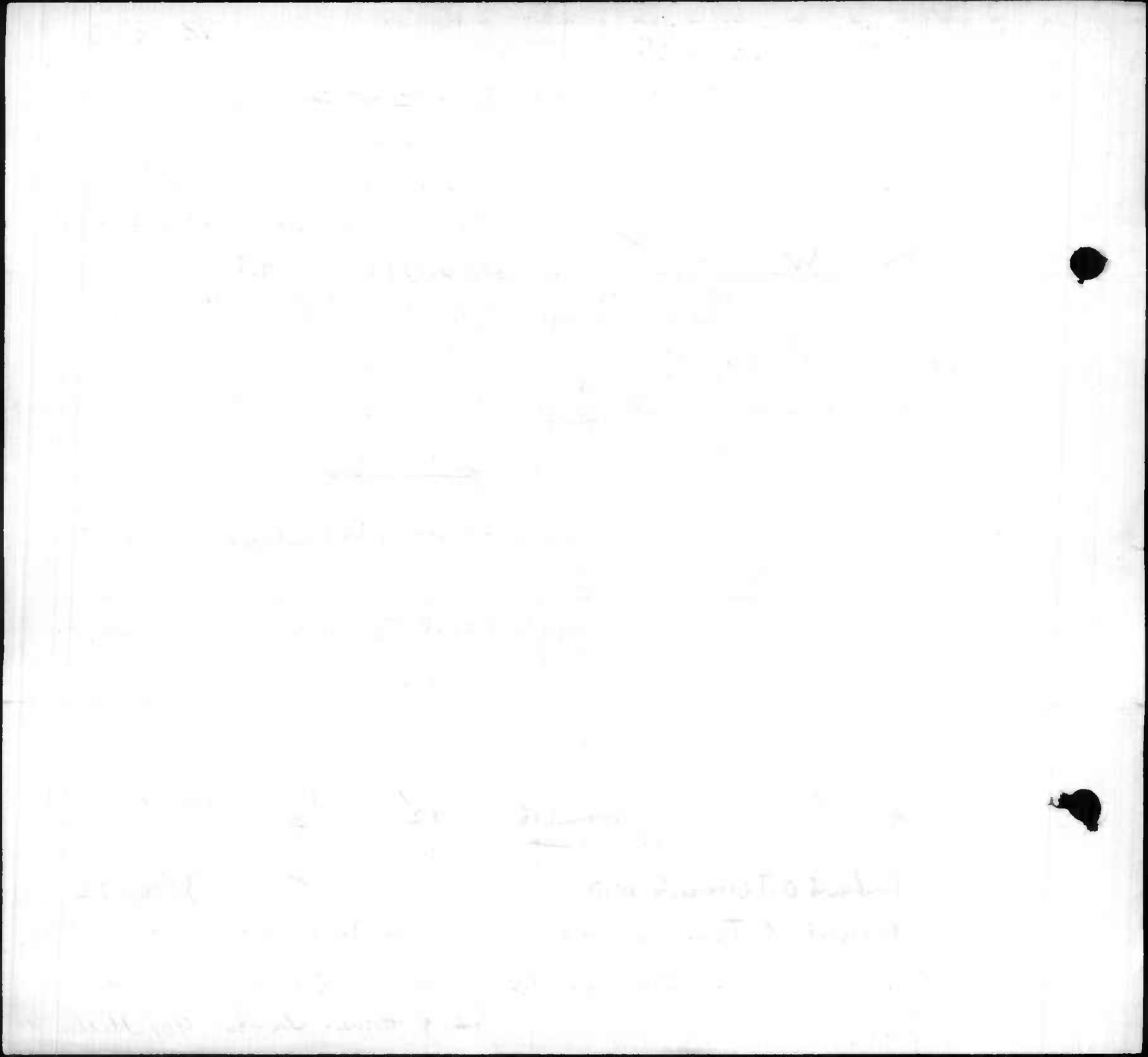
BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Bonhage		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 16 72 Hour 7:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1112 Hewitt Way		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 16 7 7:45 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2634	
9. DATE OF BIRTH Nov. 16, 1910		10. AGE (In years last birthday) 75 61 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Bonhage		14. STREET AND NUMBER 1112 Hewitt Way	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman - retired		14B. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
15. MOTHER'S MAIDEN NAME Annie Osterkamp		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year and dates of service) Yes 1941-44	
17. SOCIAL SECURITY NO. 217-26-9570		18. INFORMANT ADDRESS Family records	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 3-17-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE March 20, 1972	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Cem.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

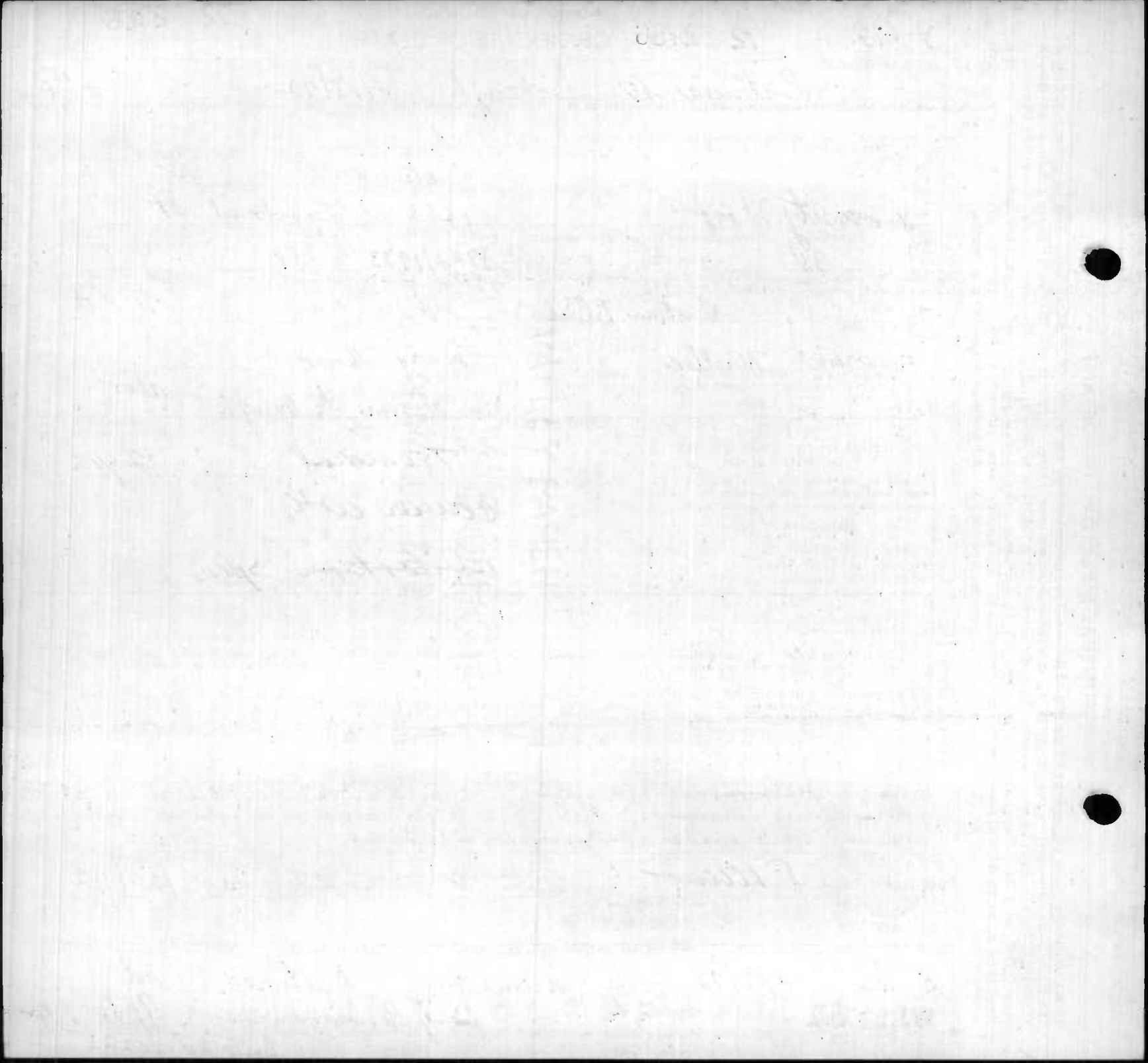
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02785	
72 02785				CERTIFICATE OF DEATH	
BIRTH NO. M-635					
1. NAME OF DECEASED (Type or Print) George Martin A/K/A GEORGE PROKOPETZ		2. DATE AND HOUR OF DEATH 3/16/72 1 7:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2003			
FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Maryland 38		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1933 Ramsay St. Balt. 21223					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/26/1922	9. AGE (In years last birthday) 49	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Andrew Prokopetz		14. MOTHER'S MAIDEN NAME Emma ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes M.M.II		16. SOCIAL SECURITY NO. 282-18-4698		17. INFORMANT Ray Martin 1933 Ramsay St. 21223	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) acute Lymphoblastic Leukemia DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month 2 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). acute Renal Failure					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from March 1 1972 to March 18 1972 that (we) last saw the deceased alive on March 18 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard A. Tomasulo M.D.		23B. DATE SIGNED 3/18/72		23C. PHYSICIAN'S NAME (Type) Richard A. Tomasulo M.D.	
23D. ADDRESS Univ. of Maryland Hospital, Balt., Md.					
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 3/21/72		24C. NAME OF CEMETERY or CREMATORY Lake View Mem. Park	
24D. LOCATION Carnell Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR John E. ...		25C. FUNERAL DIRECTOR John E. ...	
25D. ADDRESS 901 ...					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		CITY HEALTH DEPARTMENT		Baltimore City Health Department	
72 02786		72 02786		72 02786	
BIRTH NO.		72 02786		72 02786	
1. NAME OF DECEASED (Type or Print)		Patricia W. Sirbaugh		2. DATE AND HOUR OF DEATH 3/18/72 2:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Md C. CITY OR TOWN Baltimore D. STREET AND NUMBER 1413 W. Lombard St.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1933	9. AGE (In years last birthday) 38	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Venetian Blind Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lawrence Mullin		14. MOTHER'S MAIDEN NAME Mary Thompson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mr Marvin Sirbaugh	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 198.51		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Technical cancer with (B) DUE TO, OR AS A CONSEQUENCE OF: metastatic spread (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/16 1967 to 3/19 1972, that (I) (we) last saw the deceased alive on 3/18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Mullin		23B. DATE SIGNED 3/20/72			
23C. NAME OF REGISTRAR BALTO. NO. 520-90-9164		23D. ADDRESS 2232 HAMILTOWNE CIRCLE BALTO., MD. 21237			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2/22/72		24C. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR John E. ...		25C. FUNERAL DIRECTOR John E. ...	



W-251

72 02787 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02787

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Catharine</i> CATHERINE WOCHENFUSS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 14, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>44</i> Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 14, 1972 2:50 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2731			
6. SEX Female	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH August 8, 1921		10. AGE (In years last birthday) 50 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		14B. KIND OF BUSINESS OR INDUSTRY Own Home	
15. MOTHER'S MAIDEN NAME Emma Rullmann			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-18-5706	
18. INFORMANT Family records		ADDRESS	
19. 412.41 CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 15, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 18, 1972	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Fullerton, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Feltz, M.D.	
25C. FUNERAL DIRECTOR John Burns & Sons, Towson, Md.		ADDRESS	

208 S. 10th St. St. Paul, Minn.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
J. C. [Signature]

Very truly yours,
J. C. [Signature]

Enclosed for you are the following documents:

1. A copy of the report of the [Committee] on the [Subject] of the [Date].

2. A copy of the [Resolution] of the [Body] of the [Date].

3. A copy of the [Minutes] of the [Meeting] of the [Date].

4. A copy of the [Letter] of the [Date].

5. A copy of the [Circular] of the [Date].

6. A copy of the [Report] of the [Date].

7. A copy of the [Statement] of the [Date].

8. A copy of the [Declaration] of the [Date].

9. A copy of the [Petition] of the [Date].

10. A copy of the [Memorial] of the [Date].

11. A copy of the [Address] of the [Date].

12. A copy of the [Discourse] of the [Date].

13. A copy of the [Sermon] of the [Date].

14. A copy of the [Prayer] of the [Date].

15. A copy of the [Hymn] of the [Date].

16. A copy of the [Psalm] of the [Date].

17. A copy of the [Scripture] of the [Date].

18. A copy of the [Bible] of the [Date].

19. A copy of the [New Testament] of the [Date].

20. A copy of the [Gospel] of the [Date].

21. A copy of the [Epistle] of the [Date].

22. A copy of the [Apocalypse] of the [Date].

23. A copy of the [Psalms] of the [Date].

24. A copy of the [Prophets] of the [Date].

25. A copy of the [History] of the [Date].

26. A copy of the [Biography] of the [Date].

27. A copy of the [Autobiography] of the [Date].

28. A copy of the [Memoirs] of the [Date].

29. A copy of the [Lives] of the [Date].

30. A copy of the [Deaths] of the [Date].

31. A copy of the [Burials] of the [Date].

32. A copy of the [Funerals] of the [Date].

33. A copy of the [Weddings] of the [Date].

34. A copy of the [Marriages] of the [Date].

35. A copy of the [Divorces] of the [Date].

36. A copy of the [Adoptions] of the [Date].

37. A copy of the [Testaments] of the [Date].

38. A copy of the [Wills] of the [Date].

39. A copy of the [Probates] of the [Date].

40. A copy of the [Estate] of the [Date].

41. A copy of the [Inheritance] of the [Date].

42. A copy of the [Succession] of the [Date].

43. A copy of the [Trusts] of the [Date].

44. A copy of the [Deeds] of the [Date].

45. A copy of the [Contracts] of the [Date].

46. A copy of the [Agreements] of the [Date].

47. A copy of the [Pledges] of the [Date].

48. A copy of the [Oaths] of the [Date].

49. A copy of the [Vows] of the [Date].

50. A copy of the [Promises] of the [Date].

51. A copy of the [Threats] of the [Date].

52. A copy of the [Warnings] of the [Date].

53. A copy of the [Rebukes] of the [Date].

54. A copy of the [Censures] of the [Date].

55. A copy of the [Excommunications] of the [Date].

56. A copy of the [Anathemas] of the [Date].

57. A copy of the [Interdicts] of the [Date].

58. A copy of the [Excommunications] of the [Date].

59. A copy of the [Anathemas] of the [Date].

60. A copy of the [Interdicts] of the [Date].

61. A copy of the [Excommunications] of the [Date].

62. A copy of the [Anathemas] of the [Date].

63. A copy of the [Interdicts] of the [Date].

64. A copy of the [Excommunications] of the [Date].

65. A copy of the [Anathemas] of the [Date].

66. A copy of the [Interdicts] of the [Date].

67. A copy of the [Excommunications] of the [Date].

68. A copy of the [Anathemas] of the [Date].

69. A copy of the [Interdicts] of the [Date].

70. A copy of the [Excommunications] of the [Date].

71. A copy of the [Anathemas] of the [Date].

72. A copy of the [Interdicts] of the [Date].

73. A copy of the [Excommunications] of the [Date].

74. A copy of the [Anathemas] of the [Date].

75. A copy of the [Interdicts] of the [Date].

76. A copy of the [Excommunications] of the [Date].

77. A copy of the [Anathemas] of the [Date].

78. A copy of the [Interdicts] of the [Date].

79. A copy of the [Excommunications] of the [Date].

80. A copy of the [Anathemas] of the [Date].

81. A copy of the [Interdicts] of the [Date].

82. A copy of the [Excommunications] of the [Date].

83. A copy of the [Anathemas] of the [Date].

84. A copy of the [Interdicts] of the [Date].

85. A copy of the [Excommunications] of the [Date].

86. A copy of the [Anathemas] of the [Date].

87. A copy of the [Interdicts] of the [Date].

88. A copy of the [Excommunications] of the [Date].

89. A copy of the [Anathemas] of the [Date].

90. A copy of the [Interdicts] of the [Date].

91. A copy of the [Excommunications] of the [Date].

92. A copy of the [Anathemas] of the [Date].

93. A copy of the [Interdicts] of the [Date].

94. A copy of the [Excommunications] of the [Date].

95. A copy of the [Anathemas] of the [Date].

96. A copy of the [Interdicts] of the [Date].

97. A copy of the [Excommunications] of the [Date].

98. A copy of the [Anathemas] of the [Date].

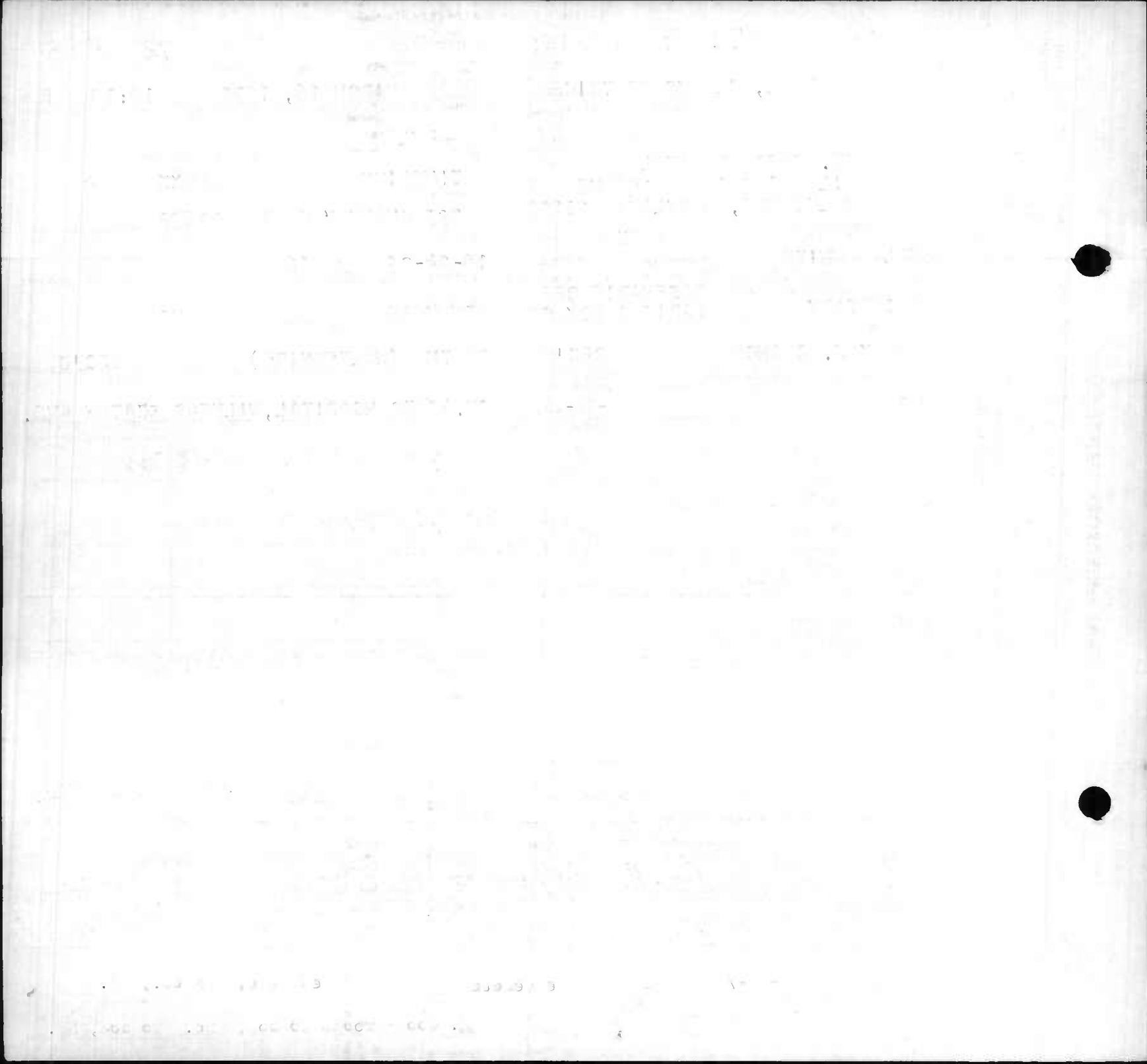
99. A copy of the [Interdicts] of the [Date].

100. A copy of the [Excommunications] of the [Date].

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

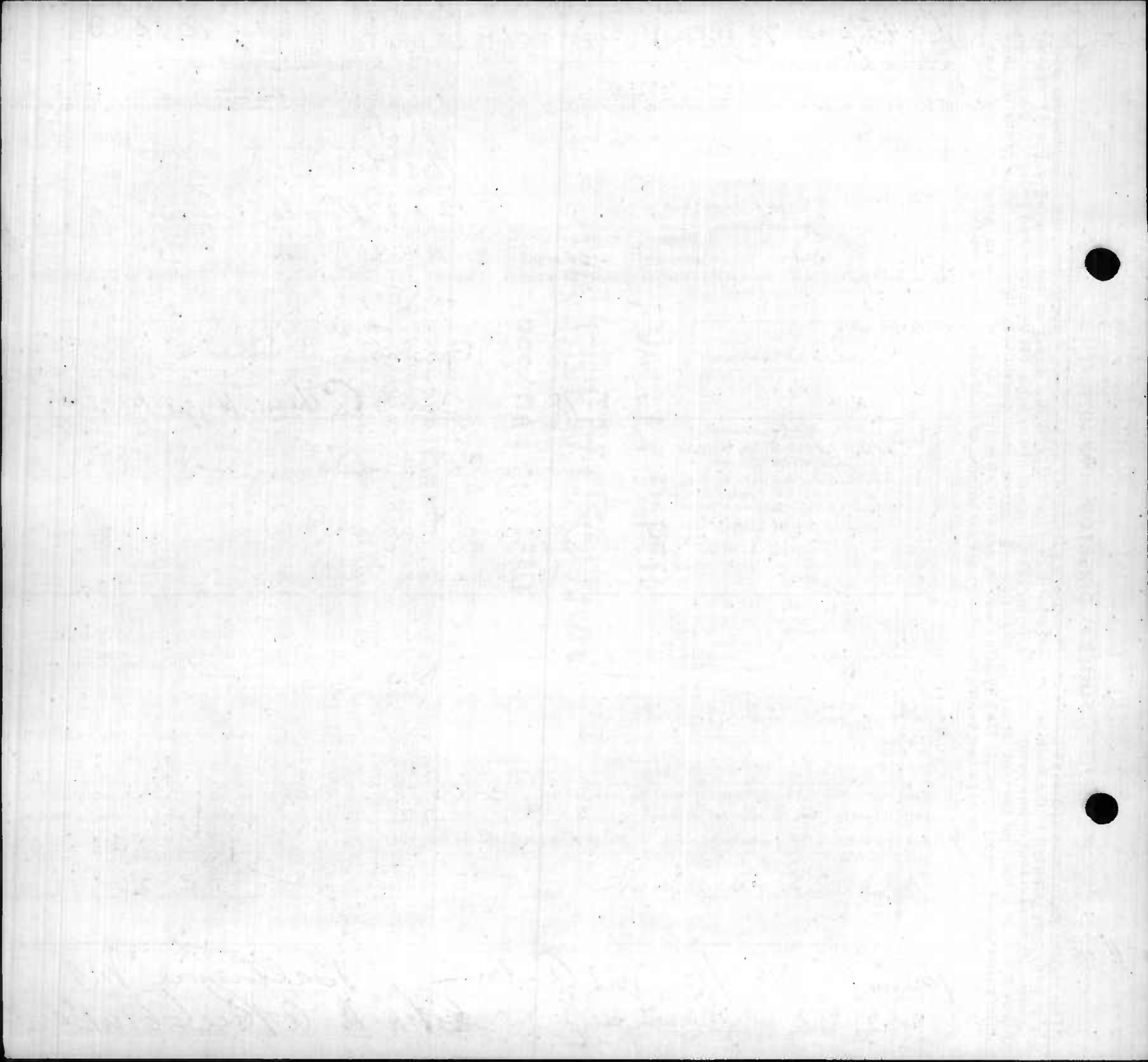
B-640		72 02788		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		72 02788	
1. NAME OF DECEASED (Type or Print) BARRELL, GLADYS BEATRICE				2. DATE AND HOUR OF DEATH MARCH 16, 1972 10:10 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO							
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229				C. CITY OR TOWN TIMONIUM				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX FEMALE				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-24-05		9. AGE (In years last birthday) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY				10B. KIND OF BUSINESS OR INDUSTRY ROSEMARIE DEE PARIS CANDY CO				11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY J. CRANCE				14. MOTHER'S MAIDEN NAME BERTHA (WALTERMIRE)				DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 068-18-4526		17. INFORMANT ST. AGNES HSOPITAL, WILKENS & CATON AVE.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MASSIVE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY ARTERY DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO			
22. I certify that (I) (this hospital) attended the deceased from JUNE 15 1953 to MARCH 16 1972 that (I) (we) last saw the deceased alive on MARCH 16 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Samuel P. Scalia, M.D. 23B. DATE SIGNED 3-16-72				23C. PHYSICIAN'S NAME (Type) SAMUEL P. SCALIA, M.D. 23D. ADDRESS 2 Shawwood Avenue Pikesville, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-20-72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972				25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452 72 02789 BIRTH NO. 68-02483		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02789	
1. NAME OF DECEASED (Type or Print) Deanna Marie Collins			2. DATE AND HOUR OF DEATH 3-19-72 9:30 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1607 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1227 Poplar Grove Sp.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-08-68	9. AGE (In years last birthday) 4	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			108. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Barbara Collins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. N/A	17. INFORMANT Aunt Catherine Heggie 1227 Poplar	
18. 347.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-pulmonary arrest acute (B) DUE TO, OR AS A CONSEQUENCE OF: Massive hydrocephalus not known (C) Unknown etiology		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0 N/A			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-06 1972 to 3-19 1972, that (I) (we) last saw the deceased alive on 3-19 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wanda M Cook			23B. DATE SIGNED 3-20-72	23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS			23E. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3/23/72	24C. NAME OF CEMETERY or CREMATORY Mt Airy	24D. LOCATION (City, Town, or county) Baltimore Md (State)
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972			25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR Charles A Rice	25D. ADDRESS 661 W Barre



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

40-52-86 1 csk				72 02790				72 02790			
BIRTH NO.				72 02790				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Lillian Rochell</u>				2. DATE AND HOUR OF DEATH <u>3/17/72</u> <u>1040</u> <u>4</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2506</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>Balt. City Hosp</u>				C. CITY OR TOWN <u>Baltimore</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Ave, Baltimore, Md. 21224</u>				E. STREET AND NUMBER <u>3439 Childs Court Baltimore, Md. 21226 007</u>							
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/89</u>	9. AGE (In years last birt) <u>73</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thad Blackwell</u>				14. MOTHER'S MAIDEN NAME <u>Alice Neal</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>4940 Eastern Ave.</u> <u>BCH Records: Baltimore, Md. 21224</u> <u>Valerie Titman</u>			
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> <u>ASCD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u> (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> <u>15 yr</u> <u>20 yr</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <u>3/13/72</u> 19 <u>72</u> to <u>3/17/72</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Daniel V. Tartaglia MD</u>				23B. DATE SIGNED <u>3/17/72</u>							
23C. PHYSICIAN'S NAME (Print) <u>DANIEL V. TARTAGLIA MD</u>				23D. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u> <u>Balt. City Hosp</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>3-21-72</u>				24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>			
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher MD</u>			
25C. FUNERAL DIRECTOR <u>Charles B. Rice</u>				25D. ADDRESS <u>661. W. Barre St.</u>							

6/19/50

X

Miss Neal

Miss Neal

Assoc. of
Misses

Miss Neal

Miss Neal

Miss Neal

13/1/50

X

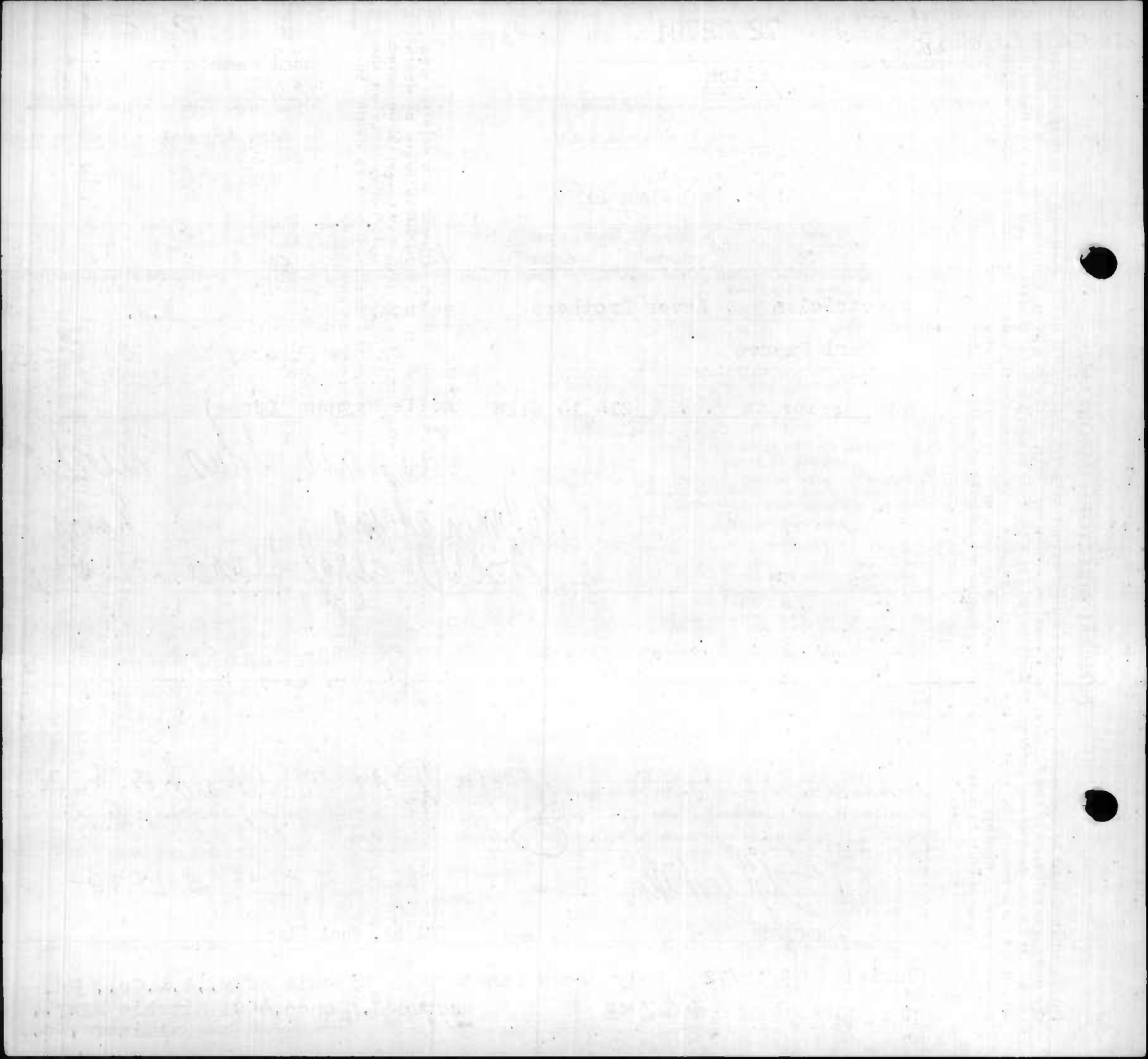
Miss Neal

Miss Neal

FUNERAL DIRECTOR: IMPORTANT

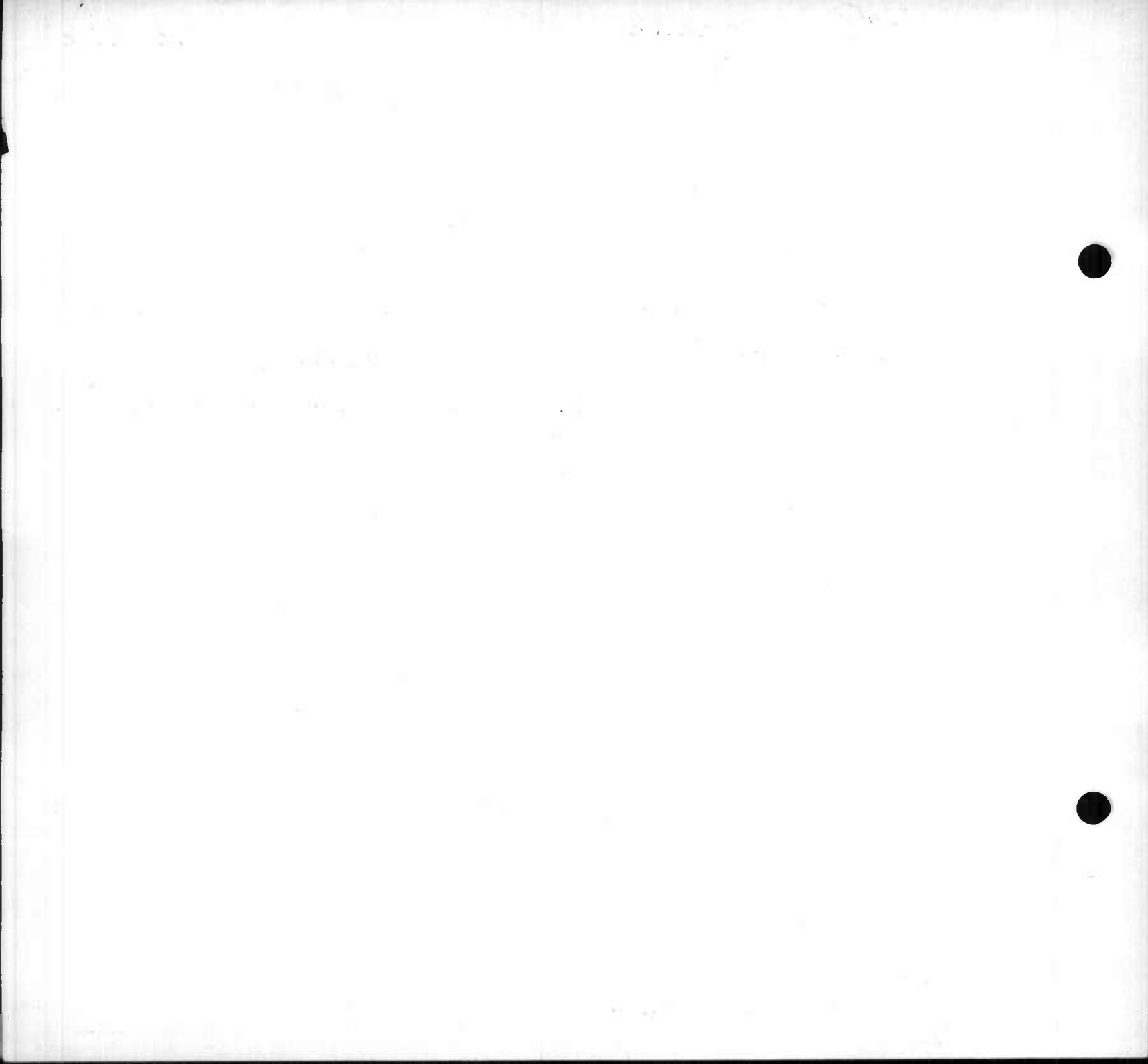
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02791	
4-520 72 02791		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Fitch Eugene Haynes</u>			2. DATE AND HOUR OF DEATH <u>3/15/72</u> <u>4:20 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <u>Mercy Hospital</u> <u>301 St. Paul Place 21202</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Glen Burnie</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>112 1/2 St. S.E. 21061</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/13</u>	9. AGE (In years last birthday) <u>58</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>Lever Brothers</u>			11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Carl Haynes</u>			14. MOTHER'S MAIDEN NAME <u>Suddie Horsley</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Prior to W.W.II</u>		16. SOCIAL SECURITY NO. <u>214 14 8118</u>	17. INFORMANT <u>Adele Haynes (same)</u>		
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary embolus</u> (B) <u>Pulmon edema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD - renal disease</u> (C) <u>etc</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>hours</u> <u>720 years</u>
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 15 2:00 AM 1972</u> to <u>March 15 2:30 AM 1972</u> , that (I) (we) last saw the deceased alive on <u>March 15 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>3-15-72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Glushakow</u>			23D. ADDRESS <u>301 St. Paul Place</u>		
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <u>Burial</u> <u>3/18/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., A.A. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>George J. Gonce</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce, 4001 Ritchie Hwy., Baltimore, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

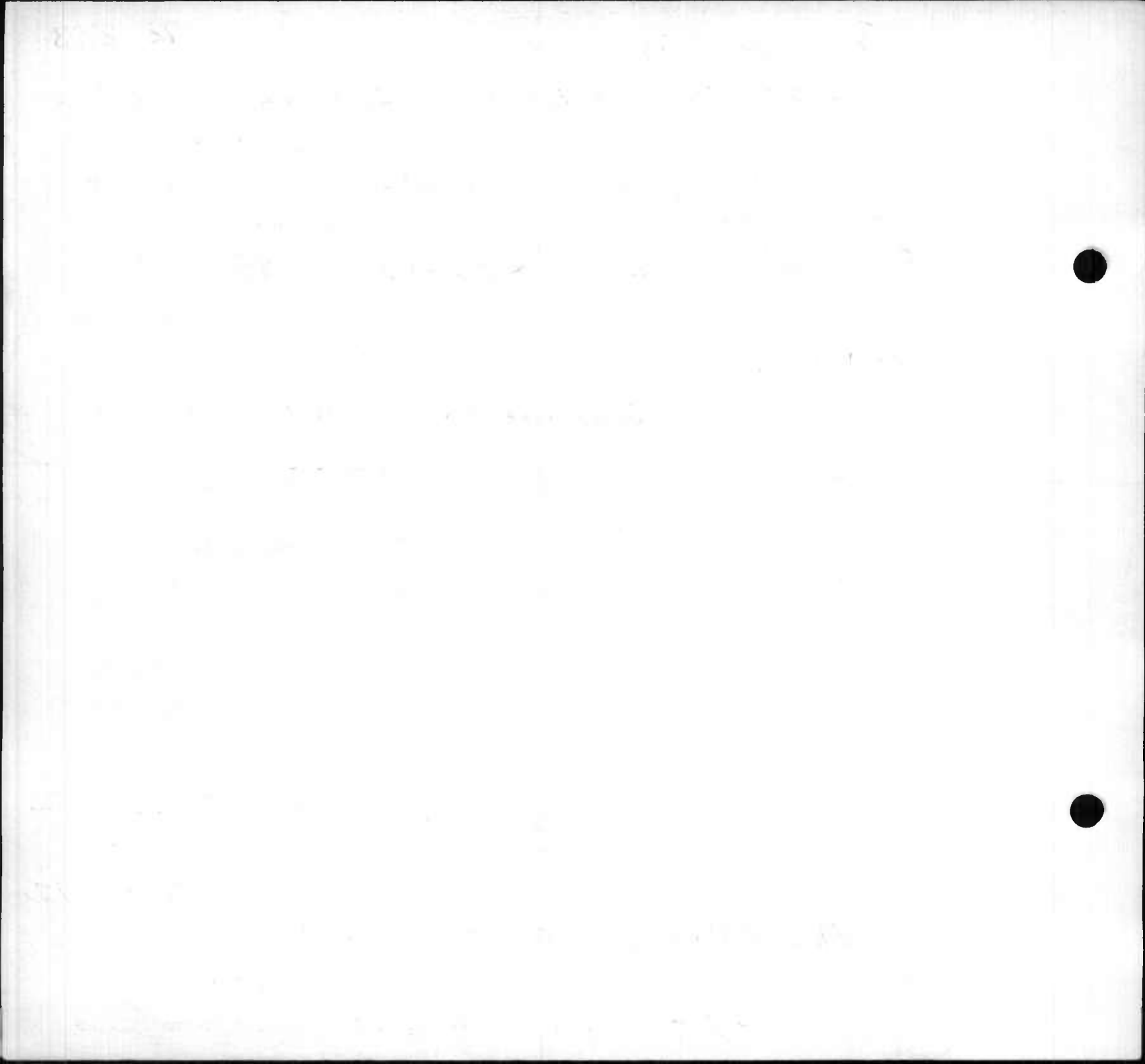
<p>W-433 72 02792 BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02792</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <i>Matthew Whayland</i></p>	
<p>2. DATE AND HOUR OF DEATH <i>3/19/72 10:35 a.m.</i></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2854</i></p>	
<p>C. CITY OR TOWN <i>Baltimore</i></p>		<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <i>4607 Pen Lucy Rd.</i></p>		<p>5. SEX <i>male</i> 6. RACE <i>white</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <i>7-10-05</i> 9. AGE (in years last birthday) <i>66</i></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat cutter</i></p>	
<p>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>USA</i></p>	
<p>13. FATHER'S NAME <i>Walter W. (late)</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Unknown</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>218-01-2248A</i></p>	
<p>17. INFORMANT <i>Mrs. Elizabeth Whayland</i></p>		<p>ADDRESS <i>21229</i></p>	
<p>18. <i>427.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>CARDIAC ARREST</i></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i></p>	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart failure</i></p>	
<p>ANTECEDENT CAUSES</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C) _____</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <i>2</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>3/15/72</i> to <i>3/19/72</i> and that (I) (we) last saw the deceased alive on <i>3/19/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Anjana Joshi</i></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>ANJANA JOSHI</i></p>		<p>23D. ADDRESS <i>MD</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>3/22/72</i></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Maryland</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>MAR 21 1972</i></p>		<p>25B. NAME OF REGISTRAR <i>Blair E. Jones, MD</i></p>	
<p>25C. FUNERAL DIRECTOR <i>Witzke</i></p>		<p>ADDRESS <i>1630 Edmondson Avenue 21228</i></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02793		CERTIFICATE OF DEATH		REG. NO. 72 02793	
BIRTH NO. <u>J-250</u>		1. NAME OF DECEASED (Type or Print) <u>Ida M. Jackson</u>		2. DATE AND HOUR OF DEATH <u>3/20/72</u> <u>2:10</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Windsor Nursing Home</u> <u>3025 Windsor Ave</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN <u>Catonsville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>921 Prestwood Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-11-86</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John O'Neill</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Deems</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213037448A</u>		17. INFORMANT ADDRESS <u>Mrs. Leona Offidani 921 Prestwood Road 21228</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>ASCVD & edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-14-1972</u> to <u>3-20-1972</u> that (I) (we) lost saw the deceased alive on <u>3-16-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Al I. Bankaler</u>				23B. DATE SIGNED <u>3-20-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Al I. BANKALER, M.D.</u>				23D. ADDRESS <u>301 Mc Mechen St. Balt, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/22/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u>		ADDRESS <u>21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-250		72 02794		72 02794	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MC KENNA, CATHERINE MARIE			MARCH 19, 1972 4:15P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229			A. STATE MD		
			B. COUNTY BALTIMORE		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 426 OVERBROOK RD.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 12 02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSEWIFE			11. BIRTHPLACE (State or foreign country) MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD CROSS			14. MOTHER'S MAIDEN NAME CATHERINE (O' CONNOR)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212 10 3286		
17. INFORMANT ST AGNES HOSPITAL WILKENS & CATON AVE.			ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute MYOCARDIAL INFARCTION</i>					
(B) <i>Ruptured Ventricle of Heart</i> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <i>Atrial Fibrillation</i>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from <u>MARCH 11,</u> 19 <u>72</u> to <u>MARCH 19,</u> 19 <u>72</u> that (X) (we) lost saw the deceased alive on <u>MARCH 19,</u> 19 <u>72</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE <i>Mahmood Tariq</i>				23B. DATE SIGNED 3-19-72	
23C. PHYSICIAN'S NAME (Type) MAHMOOD, TARIQ M.D.				23D. ADDRESS WILKENS & CATON AVE. S BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR <i>John E. Smith</i>		25C. FUNERAL DIRECTOR Witzke, 4630 Edmondson Avenue, 21228	

2-19-75

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02795	
N-143 72 02795		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) GEORGE NEBLETT		3/13/72 11:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL		A. STATE MD B. COUNTY BALTIMORE 808	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER PARK HILL NURSING HOME	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-87
9. AGE (In years lost birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Febbie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.T.		16. SOCIAL SECURITY NO. 217-074134	
17. INFORMANT MRS. COLECLOUGH (Sugawnee alone)		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of left lung	
		(B) DUE TO, OR AS A CONSEQUENCE OF: metastases	
		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-11 19 72 to 3-13 19 72 that (I) (we) last saw the deceased alive on 3-13 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael Grasso M.D.		23B. DATE SIGNED 3/13/72	
23C. PHYSICIAN'S NAME (Type) MICHAEL GRASSO M.D.		23D. ADDRESS Broughton General	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-72	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Westport, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Blaise J. J. J.	
25C. FUNERAL DIRECTOR Ellen P. P. P.		ADDRESS Home 1129 N. Caroline St.	

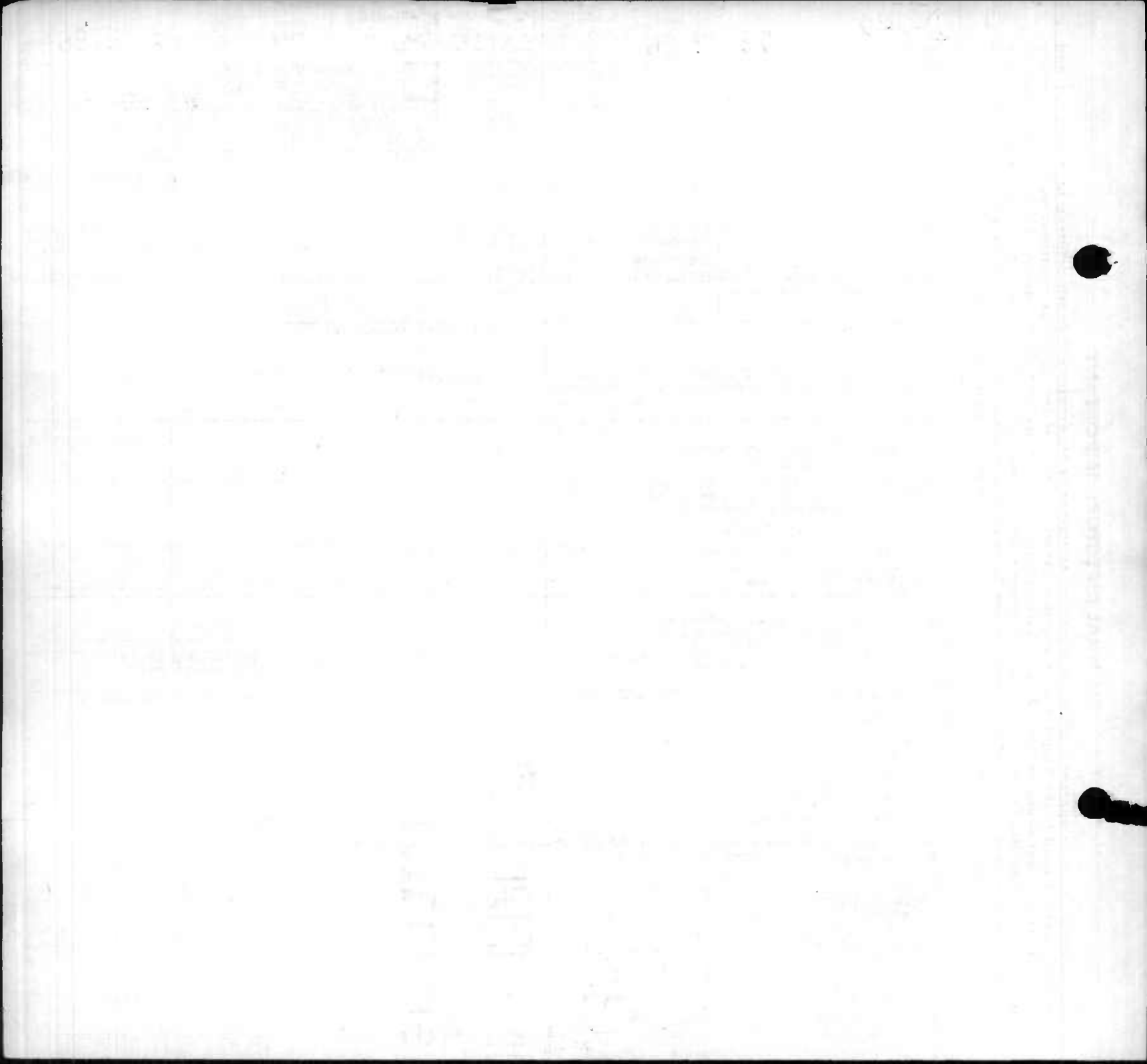
2/25/72 - Ad

1518 E. Biddle St.

FUNERAL DIRECTOR: IMPORTANT

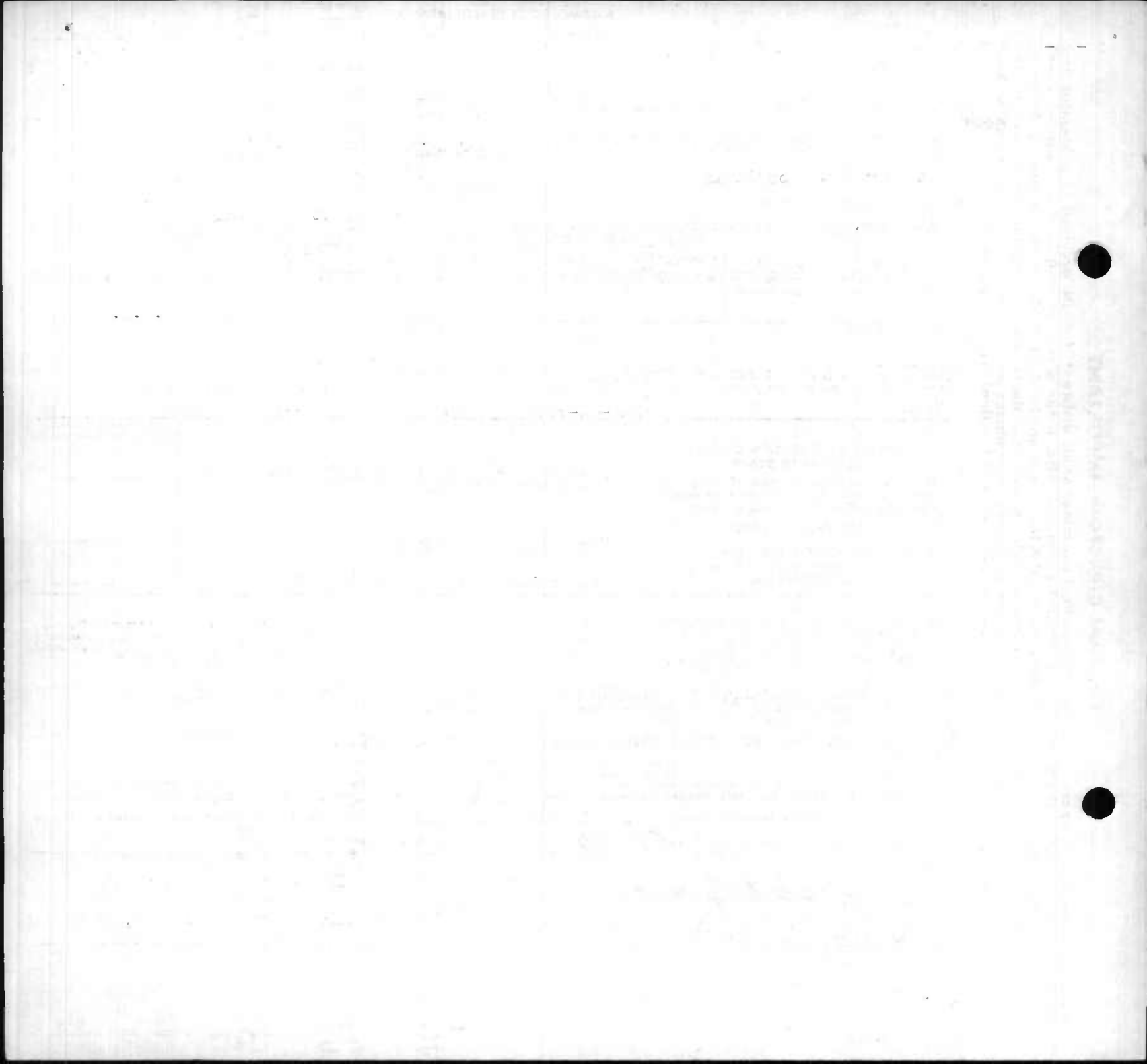
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		72 02796		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02796	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Davis, Emma</u>				2. DATE AND HOUR OF DEATH <u>3 - 19 - 72</u> <u>4:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital Inc.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1516 Luzerne Ave</u>			
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-90</u>	9. AGE (In years last birthday) <u>81</u>	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>							
13. FATHER'S NAME <u>Troy</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>216-07-9479</u>		17. INFORMANT <u>Nicholas Fuller - 5020 Dickerson Hill Rd.</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Hypertensive and atherosclerotic</u> (A) IMMEDIATE CAUSE <u>Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Diabetes Mellitus. Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus. Dehydration</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>2 - 07 - 1972</u> to <u>3 - 19 - 1972</u> that <u>(I)</u> <u>(No)</u> last saw the deceased alive on <u>3 - 19 - 1972</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(No)</u> (did) <u>(did not)</u> view the body after death.							
23A. SIGNATURE <u>Rayman I. Alley MD</u>				23B. DATE SIGNED <u>3-19-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Rayman I. Alley MD</u>				23D. ADDRESS <u>Provident Hospital Inc. Balt MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-23-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>9-9-County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>Blair E. Jones</u>		25C. FUNERAL DIRECTOR <u>Blair E. Jones</u>		ADDRESS <u>1129 N. Calvert</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

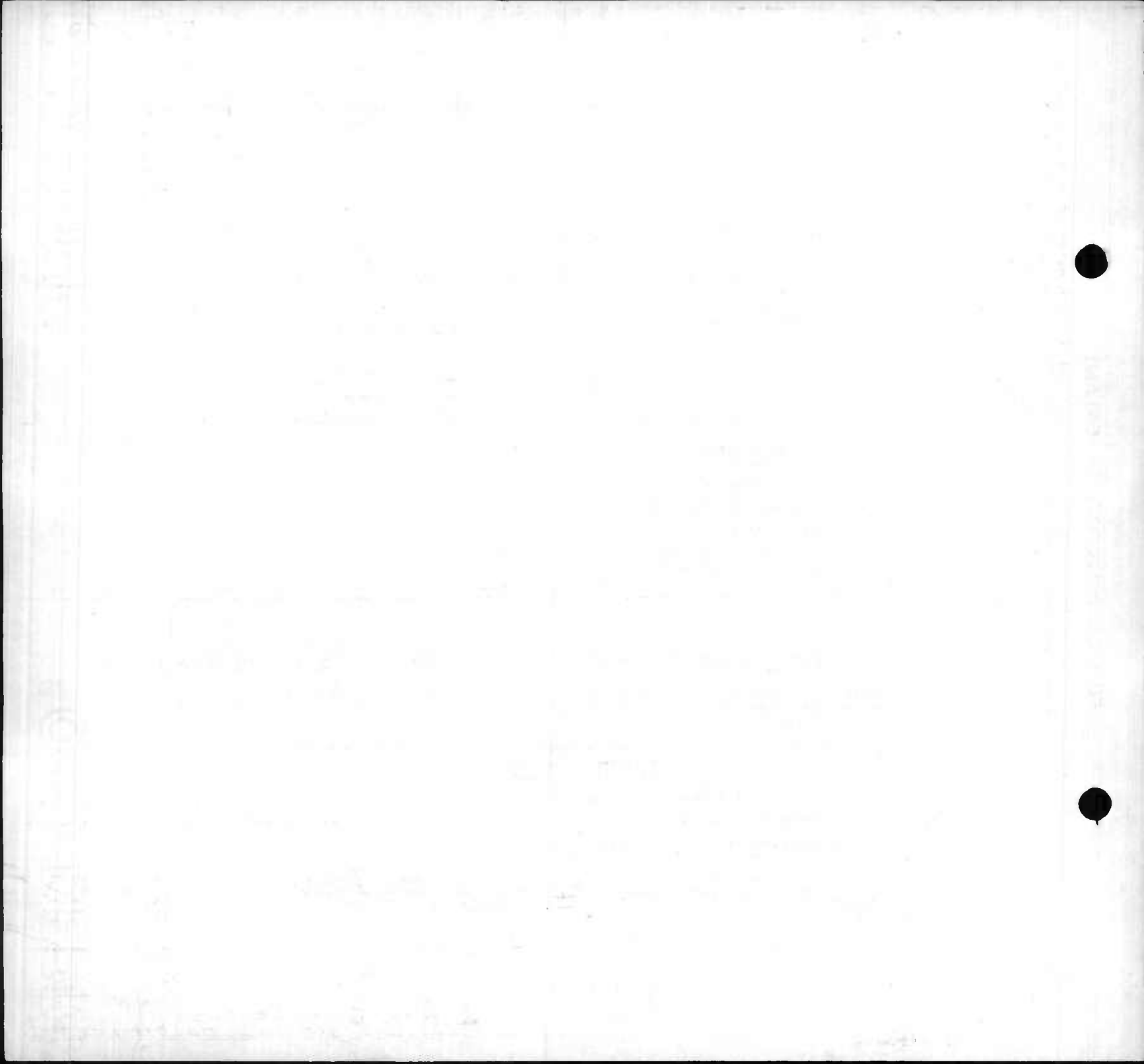
<p>Baltimore City Health Department</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>72 02797</u></p>	
<p>BIRTH NO. <u>72 02797</u></p>		<p>2. DATE AND HOUR OF DEATH <u>3/17/72</u> <u>1:29 A.M.</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Lester Davis</u></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2223 Mura Street</u> <u>21213</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>Negro</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>8/29/38</u> 9. AGE (in years last birthday) <u>33</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Alfred Grimes</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Mary Davis</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u></p>		<p>16. SOCIAL SECURITY NO. <u>216-34-7778</u></p>	
<p>17. INFORMANT <u>BCH: RECORDS Baltimore, Maryland</u></p>		<p>ADDRESS <u>4940 Eastern Avenue</u> <u>21224</u></p>	
<p>18. <u>582X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary Arrest</u> (B) <u>Pneumonia</u> (C) <u>Chronic Renal Failure</u></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>slp removal R+L kidneys; slp Transplantation</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Renal</u></p>	
<p>19A. DATE OF OPERATION <u>2/21/72</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Renal Transplant</u></p>	
<p>20A. AUTOPSY? (Yes or No) <u>YES</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Renal</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/></p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/></p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>2/21/72</u> 19 to <u>3/17/72</u> 19 that (I) (we) last saw the deceased alive on <u>3/16/72</u> 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Walter L. Gerber, MD</u></p>		<p>23B. DATE SIGNED <u>3/17/72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>Walter L. Gerber, MD</u></p>		<p>23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland</u> <u>Balt. City Hosp.</u> <u>21224</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>3-22-72</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Balto. Cemetery</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Walter L. Gerber, MD</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Walter L. Gerber, MD</u></p>		<p>ADDRESS <u>1129 N. Calver</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 02798</u>	
C-652		72 02798	
BIRTH NO. <u>72 02798</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CORONEOS, Mr. ANDREW</u>		2. DATE AND HOUR OF DEATH <u>3/17/72</u> <u>8:40 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home & Hospital</u> <u>100 NORTH BROADWAY ST.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>BALTIMORE - MARYLAND - 102</u> B. COUNTY <u>CITY</u> C. CITY OR TOWN <u>CITY</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>600 S. LINWOOD AVE</u> <u>21224</u>	
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/97</u>
9. AGE (In years last birthday) <u>74</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Candy maker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Candy</u>	
11. BIRTHPLACE (State or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>ANASTASIOS CORONEOS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ECONOMOS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W. W. I</u>		16. SOCIAL SECURITY NO. <u>216329793</u>	
17. INFORMANT <u>Mrs. Bessie Coroneos</u>		ADDRESS <u>600 S. Linwood Ave, Baltimore Md</u>	
18. <u>402X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PULMONAR EDEMA.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediately</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CIRRHOSIS of the LIVER.</u> <u>DIABETES MELLITUS.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>ATRIAL FIBRILATION - HYPERTENSION</u> (C) <u>3 months</u> <u>many years.</u>	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> 19 <u>72</u> to <u>3/17/72</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>3/17/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Dieterich V. Feldmann MD</u>		23B. DATE SIGNED <u>3/17/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DIETRICH V. FELDMANN MD</u>		23D. ADDRESS <u>3021 Eastern Ave, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-20-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>Nicholas D. Matthews</u>	
25C. FUNERAL DIRECTOR <u>3021 Eastern Ave, Baltimore, Md.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02799	
<div style="display: flex; justify-content: space-between;"> L-656 72 02799 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) Mary Larmore </div> <div> 2. DATE AND HOUR OF DEATH March 18, 1972 10:25 P. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Greenwood Acres Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 843 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2715 E. Preston Street		
5. SEX F	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/96	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 155-10-6715-T		17. INFORMANT Patients Chart ADDRESS
18. CAUSE OF DEATH 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 20 years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the undersigned) attended the deceased from May 26 19 71 to March 18 19 72 that (I) (the undersigned) last saw the deceased alive on March 16 19 72 and that in (my) (the undersigned's) opinion death occurred on the date and hour and from the causes stated above. (I) (the undersigned) (did not) view the body after death.					
23A. SIGNATURE Stanley Z. Felsenberg M.D.				23B. DATE SIGNED March 19, 1972	
23C. PHYSICIAN'S NAME (Type) Stanley Z. Felsenberg M.D.				23D. ADDRESS 1010 St. Paul St. Baltimore, Maryland 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 323 72		24C. NAME OF CEMETERY OR CREMATORY mt Calvary		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS 3307 W. North Ave. Baltimore	

M-600

72 02800

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02800

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARLTON MOORE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 12 1972 10:56a M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1303			
6. SEX male	7. RACE negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH April 15, 1902		10. AGE (In years last birthday) 69	E. STREET AND NUMBER 2200 Eutaw Place
11. BIRTHPLACE (State or foreign country) Northhampton, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Henry Moore
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disability		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Indiana Scorbrough
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-09-1508	18. INFORMANT ADDRESS Mary Turner, 4501 Norfolk Ave.
19. 412.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-13-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Kenneth Law		ADDRESS 4611 Park Heights Ave.	

1958-1-30

20

I-1

Handwritten signature

1/21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02801		72 02801	
BIRTH NO. M-256		72 02801		REG. NO.	
1. NAME OF DECEASED (Type or Print) M^{rs} WARE, JAMES LEE (NAIR)			2. DATE AND HOUR OF DEATH MARCH 19, 1972 5:40 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1512		
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER 2564 Druid Park Drive		
5. SEX MALE	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/14	9. AGE (in years last birthday) 57	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oscar McNair			14. MOTHER'S MAIDEN NAME Erie Moore		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 419018-5835		17. INFORMANT Gabrella McNair, 3511 Springdale Ave
18. 303.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CVA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: alcoholics w/ Acute Brain Syndrome.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. G. MERCANO				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M. G. MERCANO				23D. ADDRESS PROVIDENT HOSP. BALD, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/72		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972			
25B. NAME OF REGISTRAR Beneth L...		25C. FUNERAL DIRECTOR Beneth L...			
ADDRESS 4611 Park Heights Ave					

vcI

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02802

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES HUNTER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 943 W. Fayette Street				3. DATE PRONOUNCED DEAD Month Day Year Hour March 18, 1972 9:35 A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March 12, 1893				10. AGE (In years lost birthday) 79		11. BIRTHPLACE (State or foreign country) Newport News Va.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME John Hunter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper	
15. MOTHER'S MAIDEN NAME Victoria ?				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-096767	
18. INFORMANT Emma Brown				19. ADDRESS 943 W. Fayette St.		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic cardiovascular disease				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) March 18, 1972 9:35 A.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
24. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/22/72			
24C. NAME OF CEMETERY or CREMATORY W. Auburn Cem.				24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972				25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.			
25C. FUNERAL DIRECTOR Williams Funeral Home				25D. ADDRESS 319 N. Schroeder St.			

WALLACE MORRIS

WALLACE MORRIS

WALLACE MORRIS

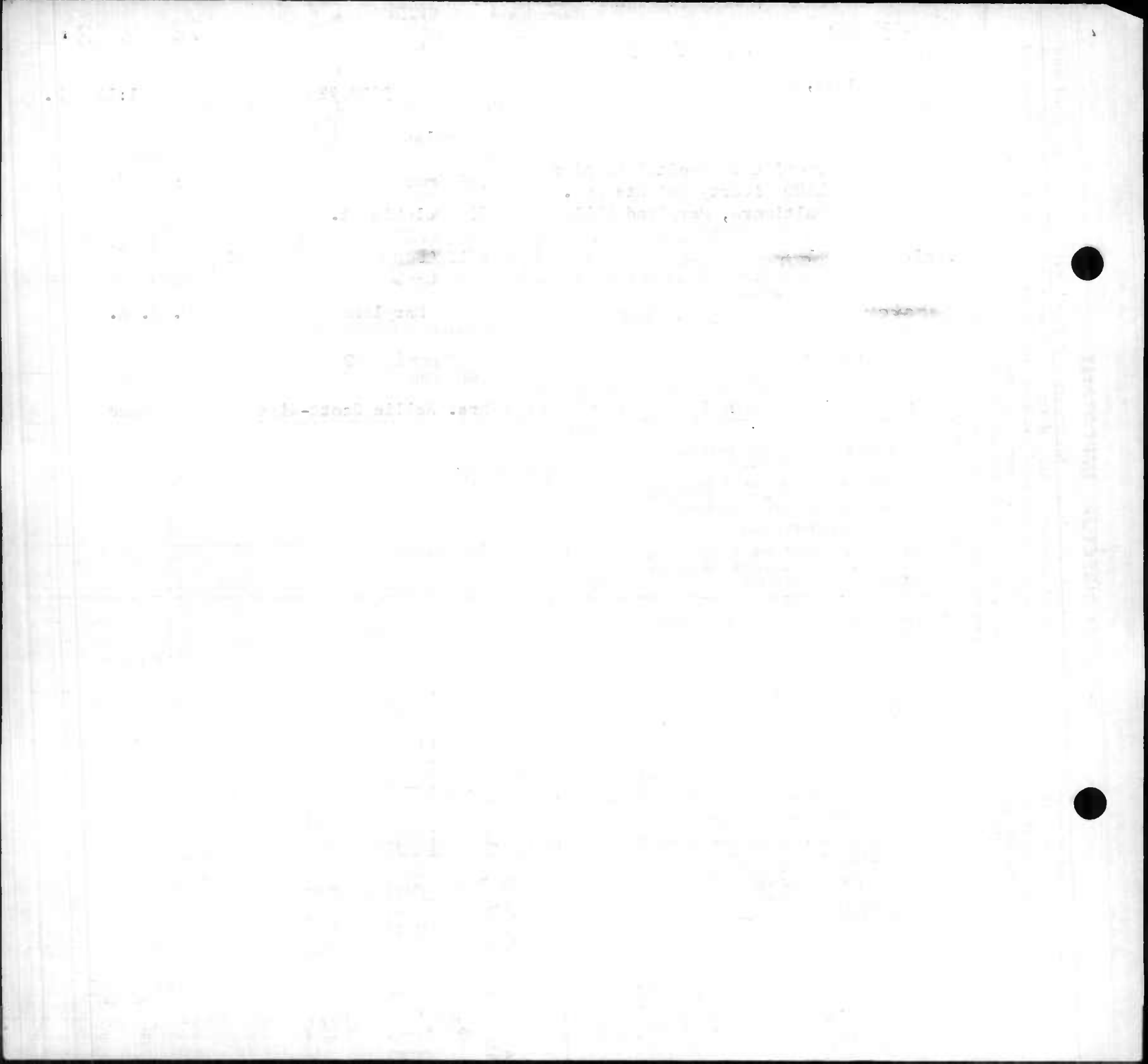
WALLACE MORRIS

WALLACE MORRIS

FUNERAL DIRECTOR: IMPORTANT

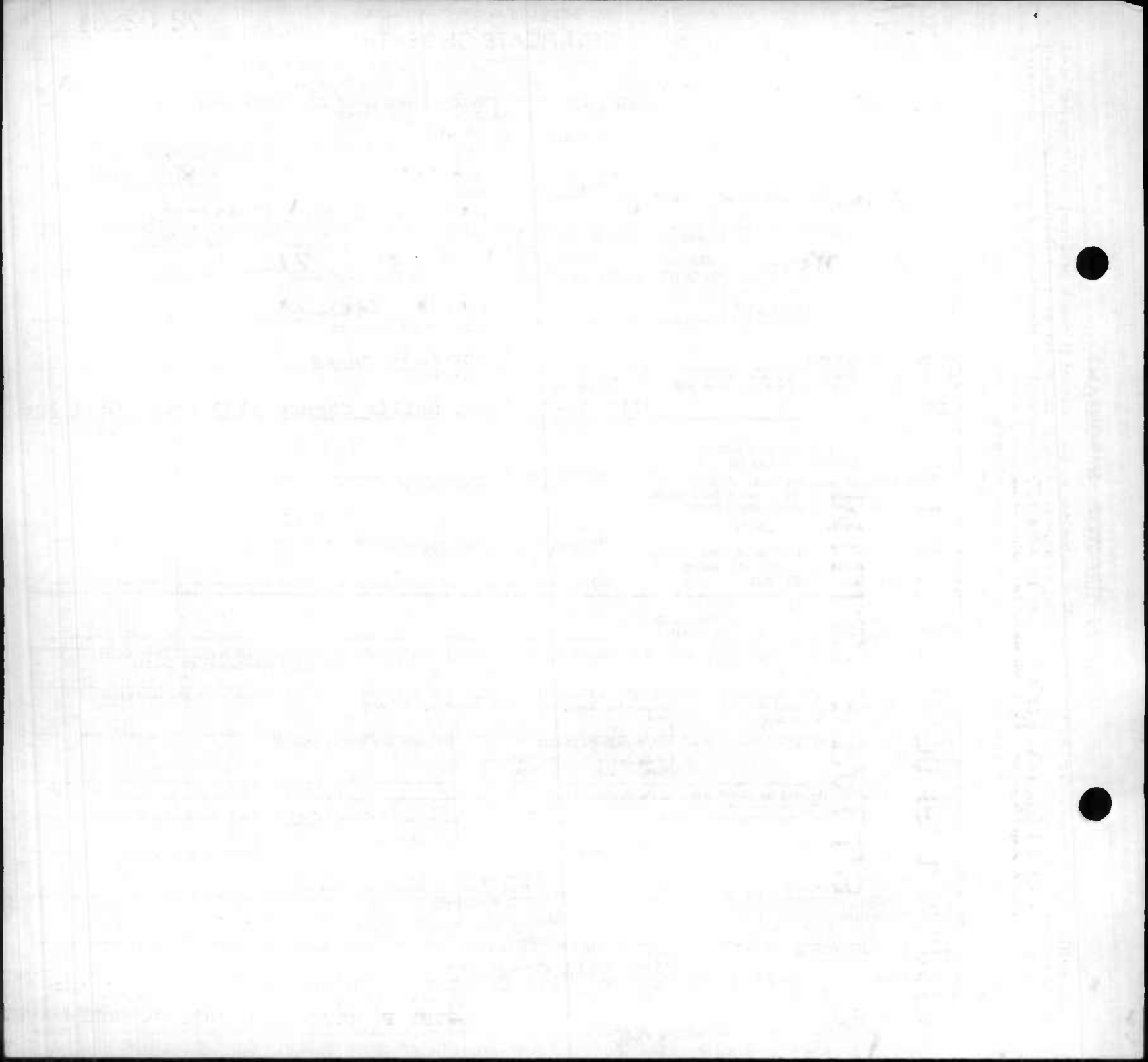
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02803		72 02803	
BIRTH NO. 8-300		72 02803		REG. NO. 72 02803	
1. NAME OF DECEASED (Type or Print) Scott, Avon B.			2. DATE AND HOUR OF DEATH 3/19/72 1:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1703 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 736 Dolphin St.		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1889	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Md. Drydock		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John Scott		
14. MOTHER'S MAIDEN NAME Carrie ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I		
16. SOCIAL SECURITY NO. 216-05-1301			17. INFORMANT Mrs. Nellie Scott-Wife		
18. ADDRESS Same			19. CAUSE OF DEATH Arteriosclerotic Heart Dis		
20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. malnutrition arteriosclerotic nephrosclerosis		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 3 mo.			23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Mar 17 1972 to Mar 19 1972 that (I) (we) last saw the deceased alive on Mar 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. H. Twining			23B. DATE SIGNED MAR 20, 1972		
23C. PHYSICIAN'S NAME (Type) R. H. TWINING			23D. ADDRESS 907 EDMONDSON AVE., BALTIMORE MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-1972		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore		24E. CITY, town, or county Maryland		24F. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Reed		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

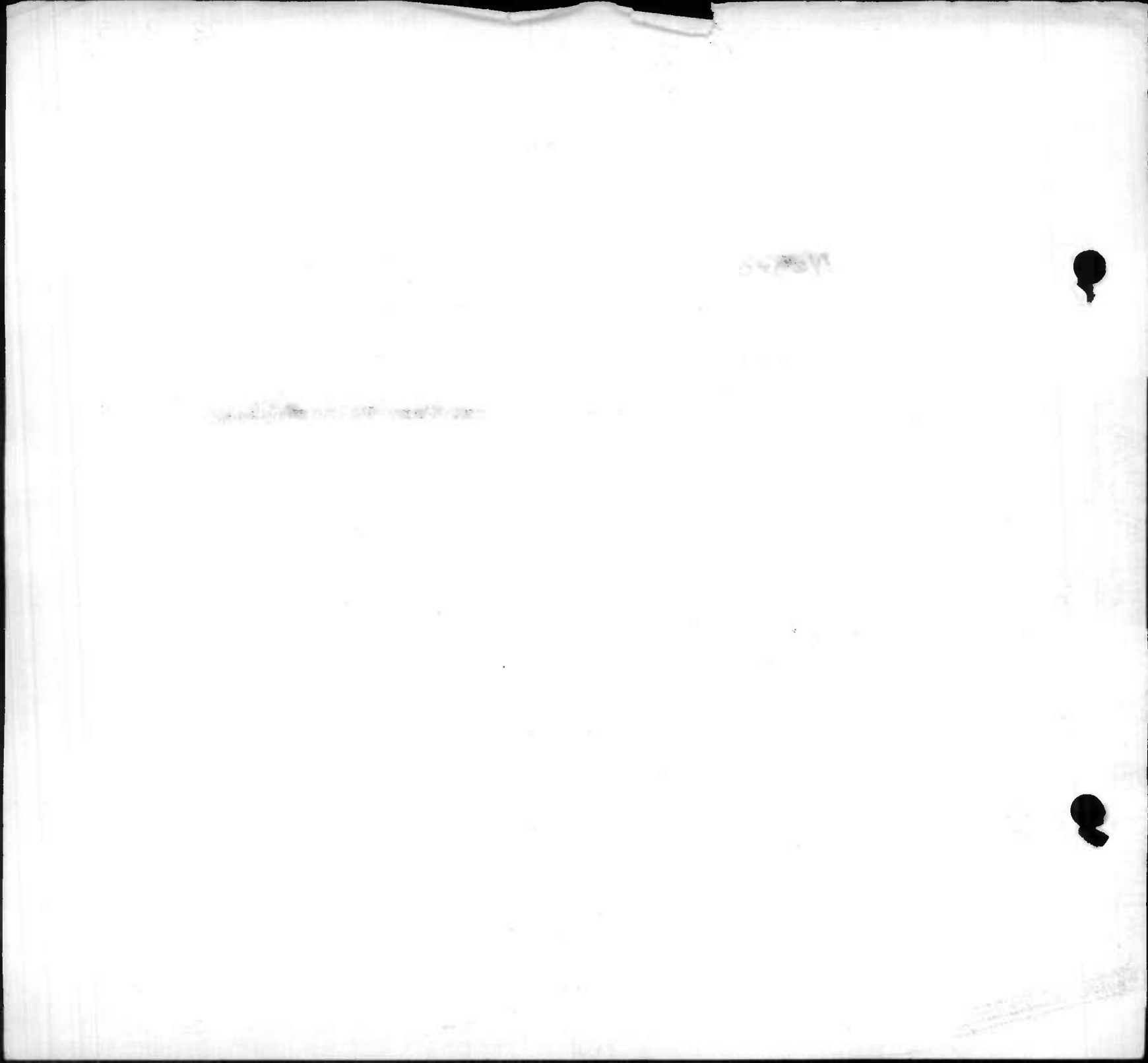
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02804</u>	
C-520 72 02804				CERTIFICATE OF DEATH	
BIRTH NO. <u>72 02804</u>		1. NAME OF DECEASED (Type or Print) <u>CLAUDE CHANCE</u>		2. DATE AND HOUR OF DEATH <u>3/17/72</u> <u>11:05</u> <u>PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1702</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harford General Hospital</u>		E. STREET AND NUMBER <u>1102 Druid Hill Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-00</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laboratory assistant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Van Chance</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Jones</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-2092</u>		17. INFORMANT <u>Mrs. Sallie Chance 1102 Druid Hill Ave.</u>	
18. <u>485X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>? Bronchopneumonia</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> 19 <u>72</u> to <u>3-17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/17/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Bayan G. Elma, M.D.</u> DEGREE	
23B. DATE SIGNED <u>3/17/72</u>		23C. PHYSICIAN'S NAME (Type) <u>BAYAN B. ELMA M.D.</u>		23D. ADDRESS <u>5355 Canby Court Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-21-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Zion Hill Cemetery</u> <u>Hubbard Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Nelson Co. Roseland R.F.D. Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>2000</u>	
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

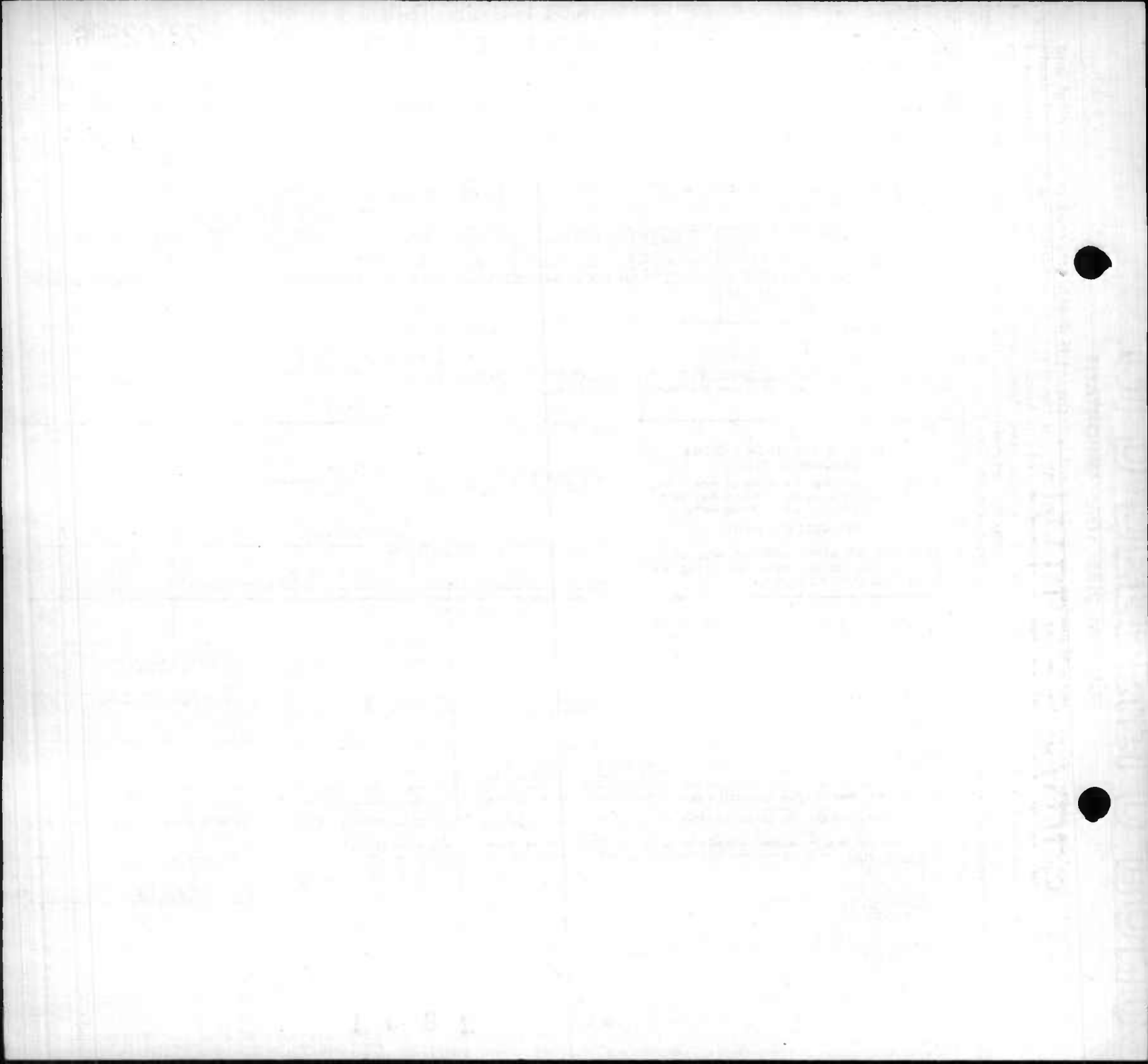
BALTIMORE CITY HEALTH DEPARTMENT				72 02805		72 02805	
BIRTH NO. <u>8-152</u>		72 02805 CERTIFICATE OF DEATH				REG. NO. <u>72 02805</u>	
1. NAME OF DECEASED (Type or Print) <u>Agnes Robinson</u>				2. DATE AND HOUR OF DEATH <u>3/13/72</u> <u>5:25</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u> <u>90</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1703</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>806 W. LANVALE ST.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-92</u>	9. AGE (In years last birthday) <u>79 yrs.</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Wootten</u>				14. MOTHER'S MAIDEN NAME <u>Mary Broshies</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-2317</u>		17. INFORMANT <u>Mrs. Mary Palmer</u> ADDRESS <u>6019 Hazel Avenue Philadelphia, Pa.</u>			
18. <u>412.41</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Artery</u> <u>A.S.C.V.D.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> 19 <u>72</u> to <u>3/13</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>3/13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joseph S. Blum</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/13/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>				23D. ADDRESS <u>1115 N. CALVERT ST</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-18-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Zuber, MD</u>		25C. FUNERAL DIRECTOR <u>NUPTER FUNERAL HOME</u> ADDRESS <u>3035 W. NORTH AVE.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02806		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02806	
1. NAME OF DECEASED (Type or Print) CASSIE J. TILGHMAN (POYS)		2. DATE AND HOUR OF DEATH MARCH 18, 1972 5⁴⁵ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND 1702			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL 48		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1309 MADISON AVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 12, 1906	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES POYS		14. MOTHER'S MAIDEN NAME Rebecca Davis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADMISSION RECORD.	
18. 712.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: STROKE (CEREBRAL EMBOLUS)		13 DAYS	
		(B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE CARDIOVASCULAR D.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 5 19 72 to MARCH 18 19 72 that (I) (we) last saw the deceased alive on MARCH 18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Balcer M.D.				23B. DATE SIGNED 3/18/72	
23C. PHYSICIAN'S NAME (Type) RICHARD H. BALCER M.D.				23D. ADDRESS MARYLAND GENERAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-72		24C. NAME OF CEMETERY OR CREMATORY Arbiter's Mem Park	
24D. LOCATION (City, town, or county) (State) Bethesda Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR PAUL J. ...	
25C. FUNERAL DIRECTOR 218 ...		ADDRESS 928 E North			



G-650

72 02807

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02807

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MABEL GREENE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 16, 1972 12:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour March 16, 1972 12:45 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2636		6. SEX Female 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Feb 24 1892 10. AGE (In years last birthday) 80 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1235 Demarcay Way	
11. BIRTHPLACE (State or foreign country) Diamond Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Kelley		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Emma George		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Betty Hefright	
19. 058.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Apparent sepsis (by history) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 16, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3-18-72	
24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert P. [Signature] M.D.	
25C. FUNERAL DIRECTOR ADDRESS WALTER DADROWSKI 1005 DUNDALK AVENUE			

5-1-1972 - Completion of cause of death on a pending medical examiner death certificate

Charles S. Springate, M.D.

HRS

S-536

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02808

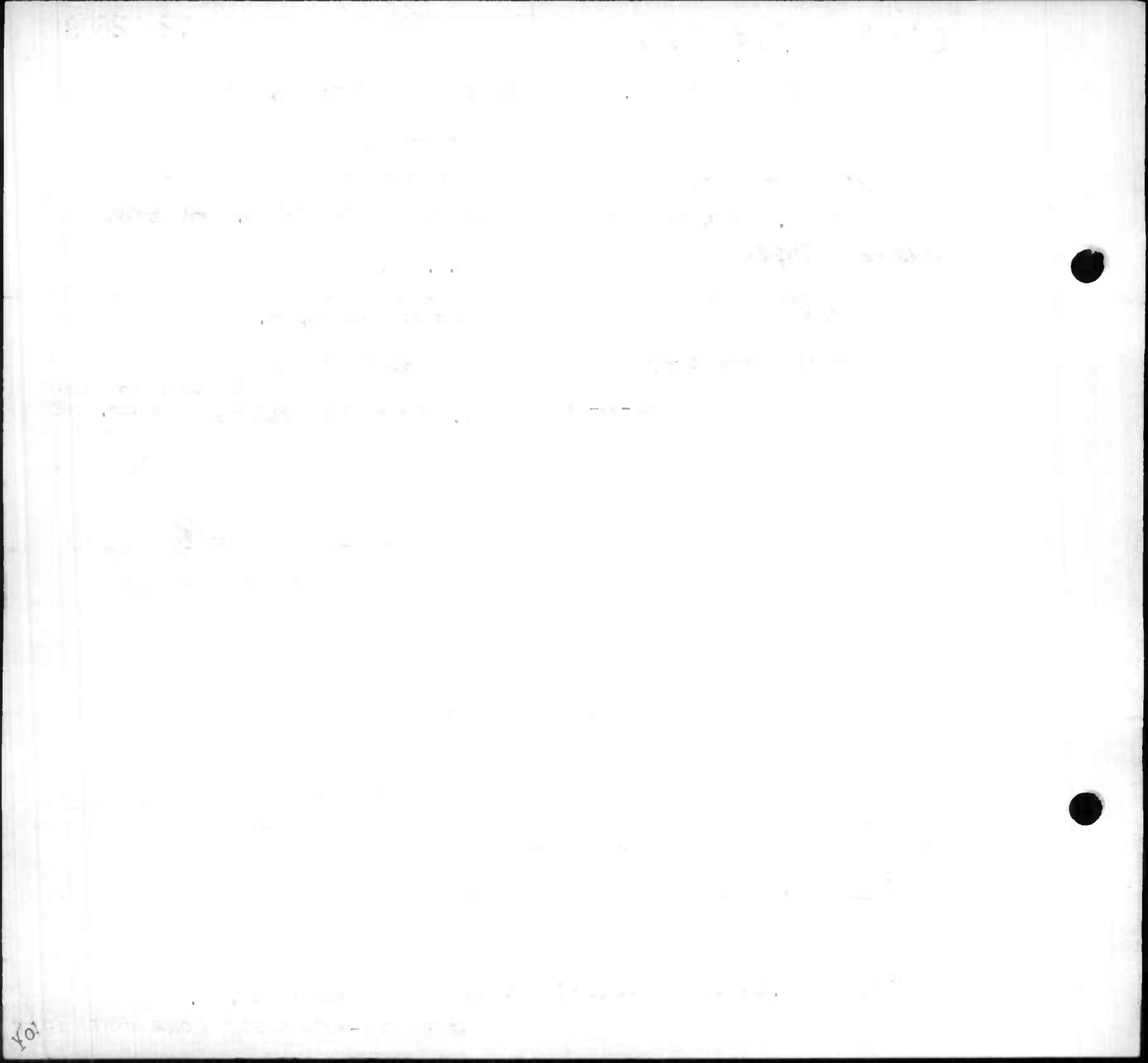
BIRTH NO.

1. NAME OF DECEASED (Type or Print) John F. Schneider		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 17 72 8:20 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 17 72 8:20 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Rogers Forge	
9. DATE OF BIRTH July 1, 1914		10. AGE (In years last birthday) 57	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Schneider		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 5300	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loan Officer		14B. KIND OF BUSINESS OR INDUSTRY Banking	
15. MOTHER'S MAIDEN NAME Anna		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 215 03 6577		18. INFORMANT Mrs. Essie B. Schneider	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-17-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/20/72	
24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Liberty Rd Woodlawn Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR John A. J. [illegible]	
25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home		ADDRESS 6500 York Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-600		72 02809		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 02809	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Miss ADA J. CURRY		MARCH 16, 1972 10:45 P		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE MARYLANDER 3501 St. PAUL STREET				MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX FEMALE				6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
at home				Sept. 6, 1882		89	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Gloucester County, Va.				USA			
13. FATHER'S NAME William Henry Curry				14. MOTHER'S MAIDEN NAME Octavia Stubbs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-8479		17. INFORMANT 106 Castlewood Road Balto. 21210 MR. DAVID DE VILLIERS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 43391 Probable pulmonary embolus (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 15 minutes				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Generalized atherosclerosis with 10 yrs. (C) 2 cerebral thromboses 542 yrs ago			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 13 1972 to March 14 1972 that (I) last saw the deceased alive on March 13 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Alan B Cohen				23B. DATE SIGNED March 17, 1972			
23C. PHYSICIAN'S NAME (Type) Alan B Cohen MD				23D. ADDRESS 3501 St Paul St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3.18/72		24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE CEMETERY		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
Burial							
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR P. J. ...		25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD		ADDRESS HOME 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02810</u>	
BIRTH NO. <u>H-500 72 02810</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Elizabeth I HANN</u>			2. DATE AND HOUR OF DEATH <u>March 15, 1972 8³⁰ PM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN <u>Catonsville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>The Silver Cross Home</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-89</u>		9. AGE (in years lost birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Drug Legal</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Francis L. Hann</u>			14. MOTHER'S MAIDEN NAME <u>Gary unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-07-7392</u>	17. INFORMANT <u>Mrs Albert Foresti 4401 Roland Ave</u>		
18. <u>519.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>A Respiratory Failure</u> (B) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <u>3/15</u> 19 <u>72</u> to <u>3/15</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>3</u> 19 <u>72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George C. Samaras</u>			23B. DATE SIGNED <u>3/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>George C. Samaras MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/18/72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Hampstead Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 21 1972</u>		25B. NAME OF REGISTRAR <u>George C. Samaras</u>		25C. FUNERAL DIRECTOR <u>M. T. H. Wiedefeld Home</u>	

4/8/70 - Adm.

4401 Roland Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-616		72 02811		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02811	
1. NAME OF DECEASED (Type or Print) CRAWFORD, JOHN				2. DATE AND HOUR OF DEATH 3/15/72 2:45 a.m. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL LINDEN AVENUE				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 1505 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3046 TOYOGO PARKWAY			
5. SEX Male	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 6, 1891	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN, WARREN CRAWFORD 705-10-2369				14. MOTHER'S MAIDEN NAME UNKNOWN HATTIE CRAWFORD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN Yes, #2008-1918		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS ADMISSION RECORD * BOLTON HILL NSG. HOME			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Brain Syndrome ASCVD, Advanced				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One Day Years Years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 10/5/71 19 71 to 3/14 19 72 that (I) (we) last saw the deceased alive on 3/14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Peter H. Rheinstein, M.D.				23B. DATE SIGNED 16 March 1972		23C. PHYSICIAN'S NAME (Type) Peter H. Rheinstein, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-20-72		24C. NAME of CEMETERY or CREMATORY Maryland National Carver		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE RECD BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Tubbs, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens St.	

3046 TIOGA PKY.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

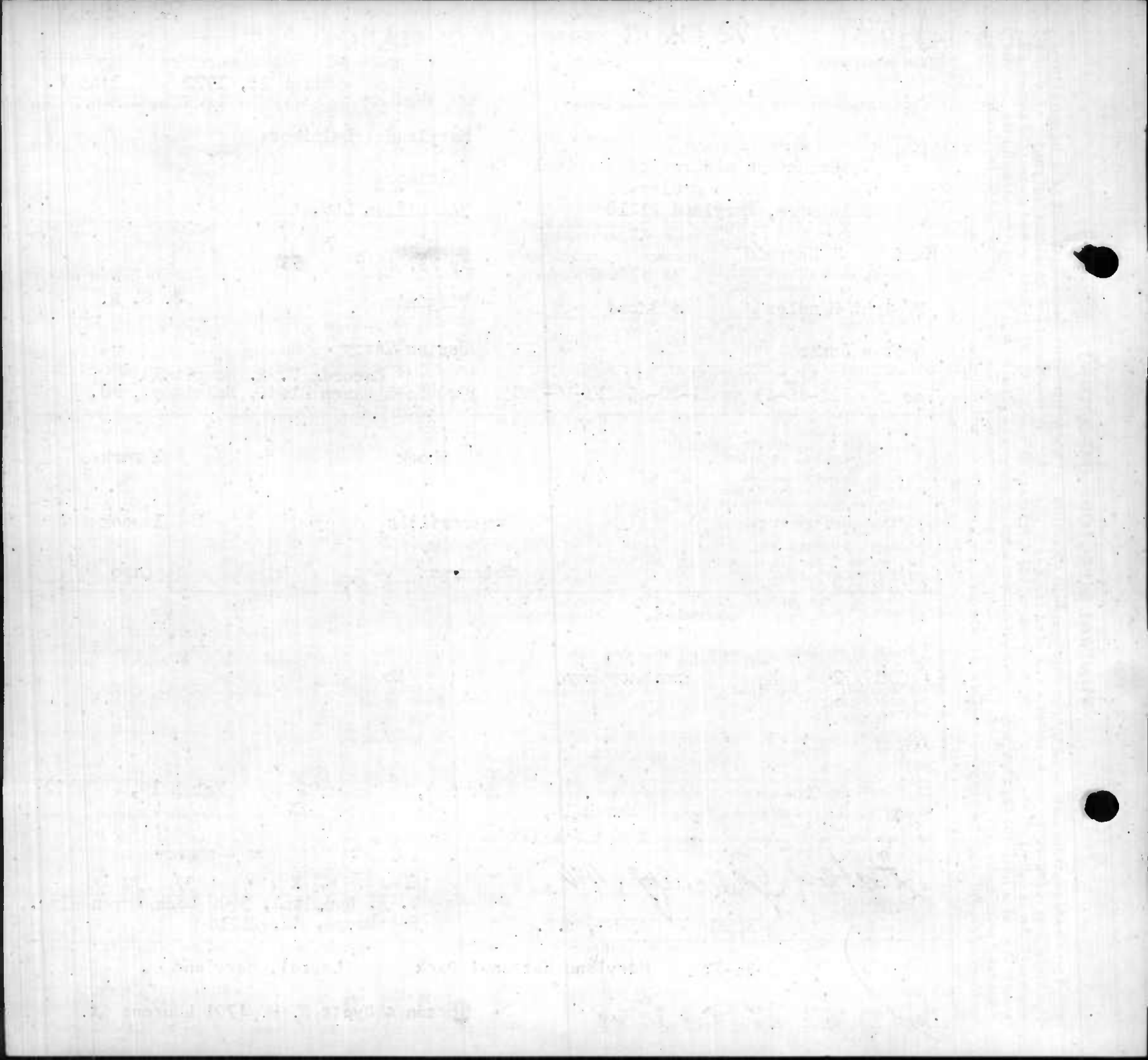
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02812	
S-530 72 02812		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) ANNE MARGARET SMITH			2. DATE AND HOUR OF DEATH 03-18-72 2:00 P.M. 806 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1727 RUTLAND AVE		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-28-33	9. AGE (In years last birthday) 38	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bugle Laundry
11. BIRTHPLACE (State or foreign country) Wadesboro, North Carolina			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME THOMAS Ratliff			14. MOTHER'S MAIDEN NAME MABEL MCLENDON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-38-8295		
17. INFORMANT Mr. Calvin C. Smith 1727 Rutland Avenue 21213			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTRA-CEREBRAL HEMORRHAGE 7 days (B) ESSENTIAL HYPERTENSION 31 (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/12/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRA CEREBRAL HEMATOMA		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/12/72 1972 to 3/18 1972 and that (I) (we) last saw the deceased alive on 3/18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin H. Epstein M.D.				23B. DATE SIGNED 3/18/72	
23C. PHYSICIAN'S NAME (Type) MELVIN H. EPSTEIN M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-72		24C. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Morton & Dyett Funeral Homes, Inc.			

THE JAMES H. HARRIS FOUNDATION
WASHINGTON, D.C. 20005
202-338-1234
FAX 202-338-1235
WWW.JHHF.ORG
JAMES H. HARRIS
FUNDATION
WASHINGTON, D.C. 20005
202-338-1234
FAX 202-338-1235
WWW.JHHF.ORG

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

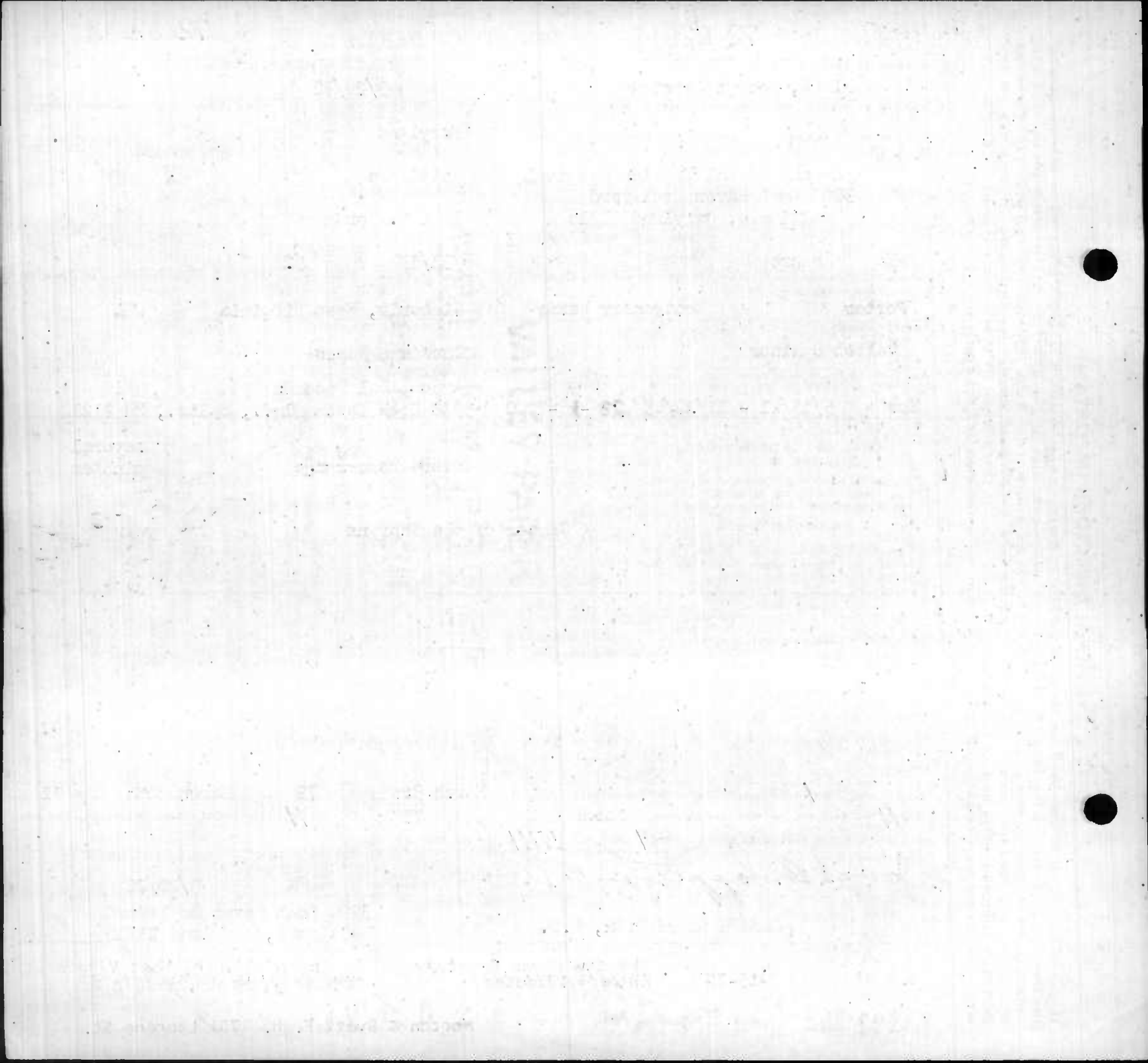
BALTIMORE CITY HEALTH DEPARTMENT		72 02813		72 02813	
BIRTH NO. <u>J-520</u>		72 02813		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JONES, WALLACE R.			2. DATE AND HOUR OF DEATH March 19, 1972 1:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 346 Hilton Street		
5. SEX Male	6. RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1918	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME George Jones		
14. MOTHER'S MAIDEN NAME Hester Terry			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12-10-43 to 12-20-45		
16. SOCIAL SECURITY NO. 213-10-8575			17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Shock				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pancreatitis				1 week	
(B) DUE TO, OR AS A CONSEQUENCE OF: Seizures				years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/17/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 7, 1972 to March 19, 1972 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 19, 1972 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) XXXX view the body after death.					
23A. SIGNATURE <i>Stephen Greenberg, M.D.</i> OEGREE				23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Type) STEPHEN GREENBERG, M.D. OEGREE				23D. ADDRESS V. A. Hospital, 3900 Loch Raven Blvd., Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-72		24C. NAME OF CEMETERY OR CREMATORY Maryland National Park	
24D. LOCATION (City, town, or county) (State) Laurel, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972			
25B. NAME OF REGISTRAR Bessie H. H. H.		25C. FUNERAL DIRECTOR Morton E. Dyett F. H.			
ADDRESS 1701 Laurens St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02814
M-560		72 02814		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MINOR, George Overton		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 3/20/72 M.		
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1303		
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY Montgomery Wards		8. DATE OF BIRTH 5/31/19
13. FATHER'S NAME Culton O Minor		11. BIRTHPLACE (State or foreign country) Kimberly, West Virginia		9. AGE (In years last birthday) 52
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/13/41 - 11/24/45		16. SOCIAL SECURITY NO. 235-16-7200		12. CITIZEN OF WHAT COUNTRY? USA
17. INFORMANT VA Hospital Records		14. MOTHER'S MAIDEN NAME Jessie M Burks		
18. 149X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Severe hemorrhage		17. INFORMANT ADDRESS VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218		
19. DATE OF OPERATION 0		20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Severe hemorrhage		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from March 3rd 19 72 to March 20th 19 72 , that (I) (we) last saw the deceased alive on March 20th 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Joseph B. Sappington, M.D. DEGREE		
23B. DATE SIGNED 3/20/72		23C. PHYSICIAN'S NAME (Type) JOSEPH SAPPINGTON, M.D. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-72		
24C. NAME OF CEMETERY OR CREMATORY Meadow Haven Cemetery		24D. LOCATION (City, town, or county) (State) Ingram Branch, West Virginia		
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		
25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens St.				




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02815

BIRTH NO. K400		72 02815	
1. NAME OF DECEASED (Type or Print) KELLY, HENRY DOUGLAS		2. DATE AND HOUR OF DEATH MARCH 20, 1972 12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1304 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2318 BRYANT AVENUE	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09/10/19
9. AGE (In years last birthday) 52		10. CITIZEN OF WHAT COUNTRY? U S A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME KELLY, PERSON		14. MOTHER'S MAIDEN NAME GARRISON, HETTIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216127699	
17. INFORMANT CATON AVES., BALTO., ADDRESS 21229 ST AGNES HOSPITAL RECORDS, WILKENS &			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 283.9 I CAUSE OF DEATH Bleeding stomach ulcer (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hoemolytic anemia (B) DUE TO, OR AS A CONSEQUENCE OF: Possible Autoimmune Disease (C) Atelectasis left lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 2 months 11 11 undetermined	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that XX (this hospital) attended the deceased from MARCH 17, 19 72 to MARCH 20, 19 72 that X (we) last saw the deceased alive on MARCH 20, 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Type) DANIEL HUERTA, M.D. Daniel Huerta, M.D.		23D. ADDRESS ST AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-72	
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 21 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Robert E. Fisher, M.D.		25D. ADDRESS 10000 Dyett F.H. - 1001 - 1001	

KELLY, BERRY DONALD

MARCH 2, 1975

ST AGNES HOSPITAL

2318 S Y ST AVENUE

DEPT XX

DEPT 13

1975

MALE

ST AGNES

SOUTH CAROLINA

KELLY, BERRY

BARRISON, BETTIE

2318758

NO

ST AGNES HOSPITAL RECORDS, WILKINS

History of the machine where

A his

History of the machine

Possible Automobile Driver

Admission of self

MARCH 20

MARCH 11

MARCH 20

XX

X

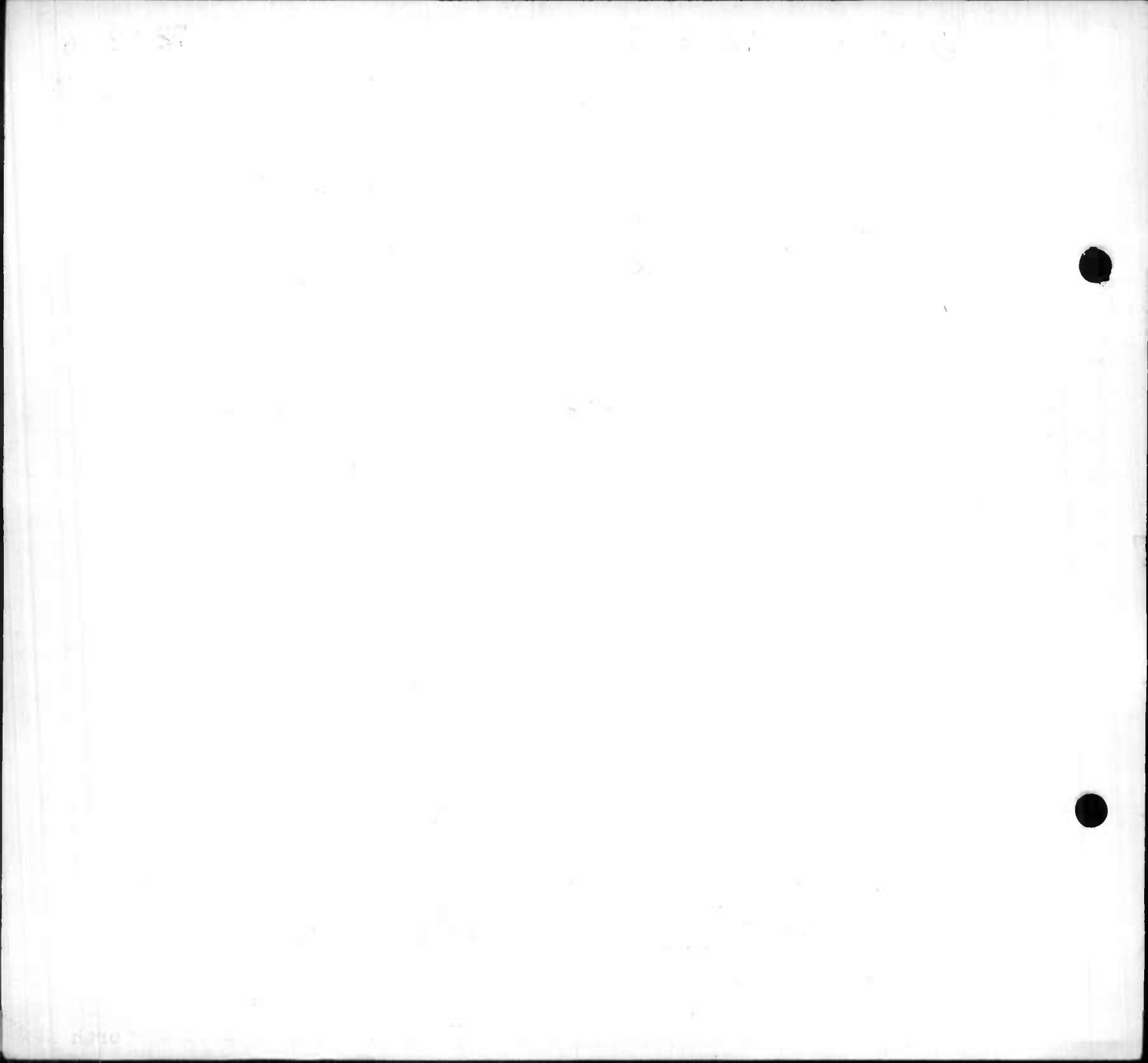
3/30

[Signature]

Daniel H. H. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02816		72 02816	
BIRTH NO. <u>D-541</u>		72 02816		REG. NO. <u>72 02816</u>	
1. NAME OF DECEASED (Type or Print) <u>DUNLAP. ALONZO F</u>		2. DATE AND HOUR OF DEATH <u>3-20-1972. 4:55 P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1501</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN OF MARYLAND</u> <u>730 Ashburton, ST</u>		C. CITY OR TOWN <u>BALTO-MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1521 Pressman St</u>			
5. SEX <u>M.</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/10/10</u>	9. AGE (In years last birthday) <u>61</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Ill yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>249-05-4615</u>		17. INFORMANT <u>M's Grace Littles, Same</u>	
18. <u>0119 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>2 PULMONARY T.B.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3 19 72</u> to <u>3 20 19 72</u> that (I) (we) last saw the deceased alive on <u>3 20 19 72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>SAMUEL J. EDWIN MD.</u>		23B. DATE SIGNED <u>3.20.1972.</u>		23C. PHYSICIAN'S NAME (Type) <u>SJ Edwin</u>	
23D. ADDRESS <u>LUTHERAN HOSPITAL, BALTO, MD #16.</u>		23E. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/25/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Md</u>		24E. ADDRESS <u>Baltimore, Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Ben, MD.</u>		25C. ADDRESS <u>Baltimore, Md</u>	



8524

72 02817

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02817

REG. NO.

BIRTH NO.

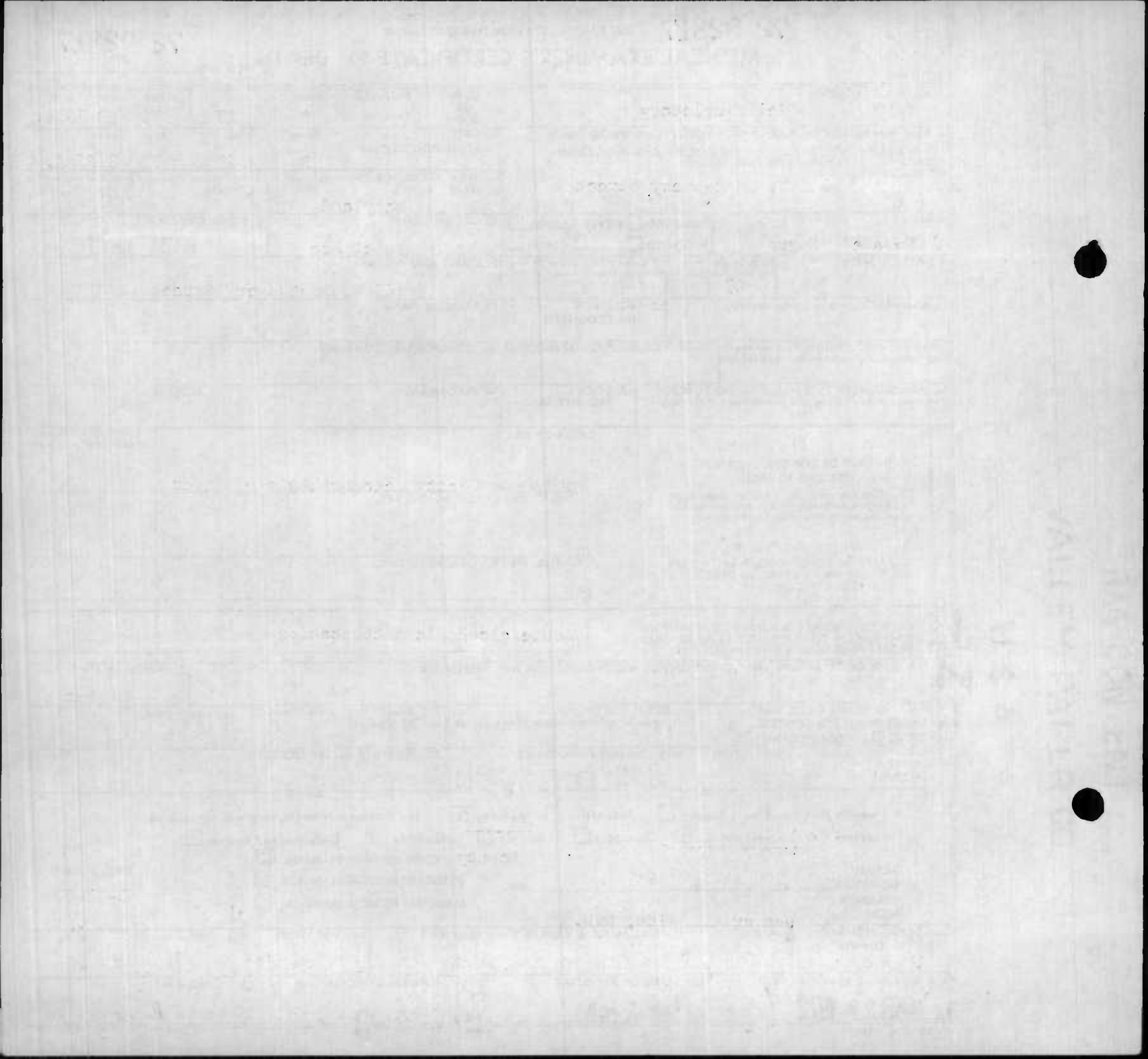
1. NAME OF DECEASED (Type or Print) Odel Singletary		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 17 Year 72 Hour 2:55 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 145 W. Montgomery Street		3. DATE PRONOUNCED DEAD Month 3 Day 17 Year 72 Hour 2:55 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201	
9. DATE OF BIRTH		10. AGE (in years last birthday) 47	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

MEDICAL CERTIFICATION	19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) Acute alcoholic intoxication

20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/72	
24C. NAME OF CEMETERY or CREMATORY Mount Calvary		24D. LOCATION (City, town, or county) (State) A.A. Co., Md	

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
MAR 22 1972	Robert E. [illegible]	12 [illegible]	12 [illegible] in Montgomery St



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-265		72 02818		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02818	
1. NAME OF DECEASED (Type or Print) SAGARINO, HARRY				2. DATE AND HOUR OF DEATH March 7, 1972 2:30 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Good Samaritan Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 201			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1927 East Pratt Street			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/98	9. AGE (In years last birthday) 73	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Frank Sagarino				14. MOTHER'S MAIDEN NAME Daisy Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 578 26 2240		17. INFORMANT Patient (Med. Record)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC OBSTRUCTIVE PULMONARY DIS. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (H) (this hospital) attended the deceased from 7/15/71 19 to 3/7/72 19 that (I) (we) last saw the deceased alive on 3/6/ 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. 23A. SIGNATURE <i>Alfred Munzer MD</i> 23B. DATE SIGNED March 7, 1972 23C. PHYSICIAN'S NAME (Type) Alfred Munzer, M.D. 23D. ADDRESS 1 University Parkway East Baltimore Md ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD 24A. BURIAL CREMATION, REMOVAL (Specify) 3-14-72 24B. DATE 3-14-72 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town or county) (State) 25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS							

81850-55

2-962

1

B-200

72 02819

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02819

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) WILLIS A. BAUGH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 1-27-72		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8 E. Preston Street		3. DATE PRONOUNCED DEAD Month Day Year January 27, 1972		Hour 4:06 A.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1102				
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 71		10. AGE (In years last birthday) 71		E. STREET AND NUMBER 8 E. Preston Street
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS
19. 712.4 I CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 27, 1972				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-14-72		24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS

Page 1

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION OF THE HOUSE OF REPRESENTATIVES

PASSED MAY 1, 1890

AND A RESOLUTION OF THE SENATE

PASSED MAY 1, 1890

RELATIVE TO THE LANDS BELONGING TO THE STATE

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

AND TO THE MANNER OF DISPOSING OF THEM

W-425

72 02820

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02820

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) RUTH WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour M. 2 6 1972 11:20a	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 402		6. SEX female 7. RACE negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	

19. 571.81 CAUSE OF DEATH Fatty liver DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)		DATE SIGNED 2-7-72		

24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-14-72		24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL	
				25D. ADDRESS MORTUARY SERVICE - BCHD	

CHS, ST

CHS, ST

CHS, ST

CHS, ST

CHS, ST

CHS, ST

CHS, ST

CHS, ST

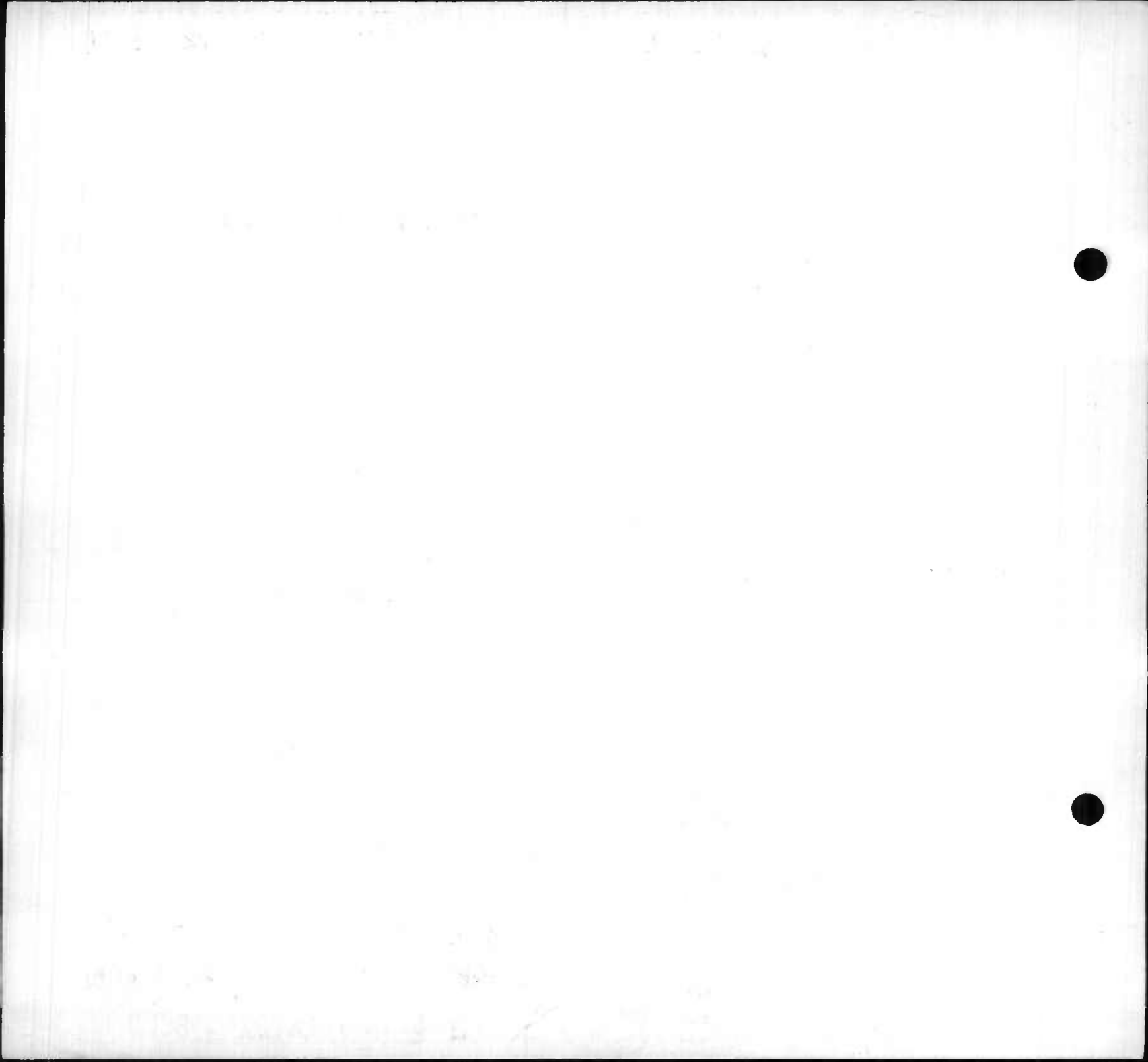
CHS, ST

CHS, ST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

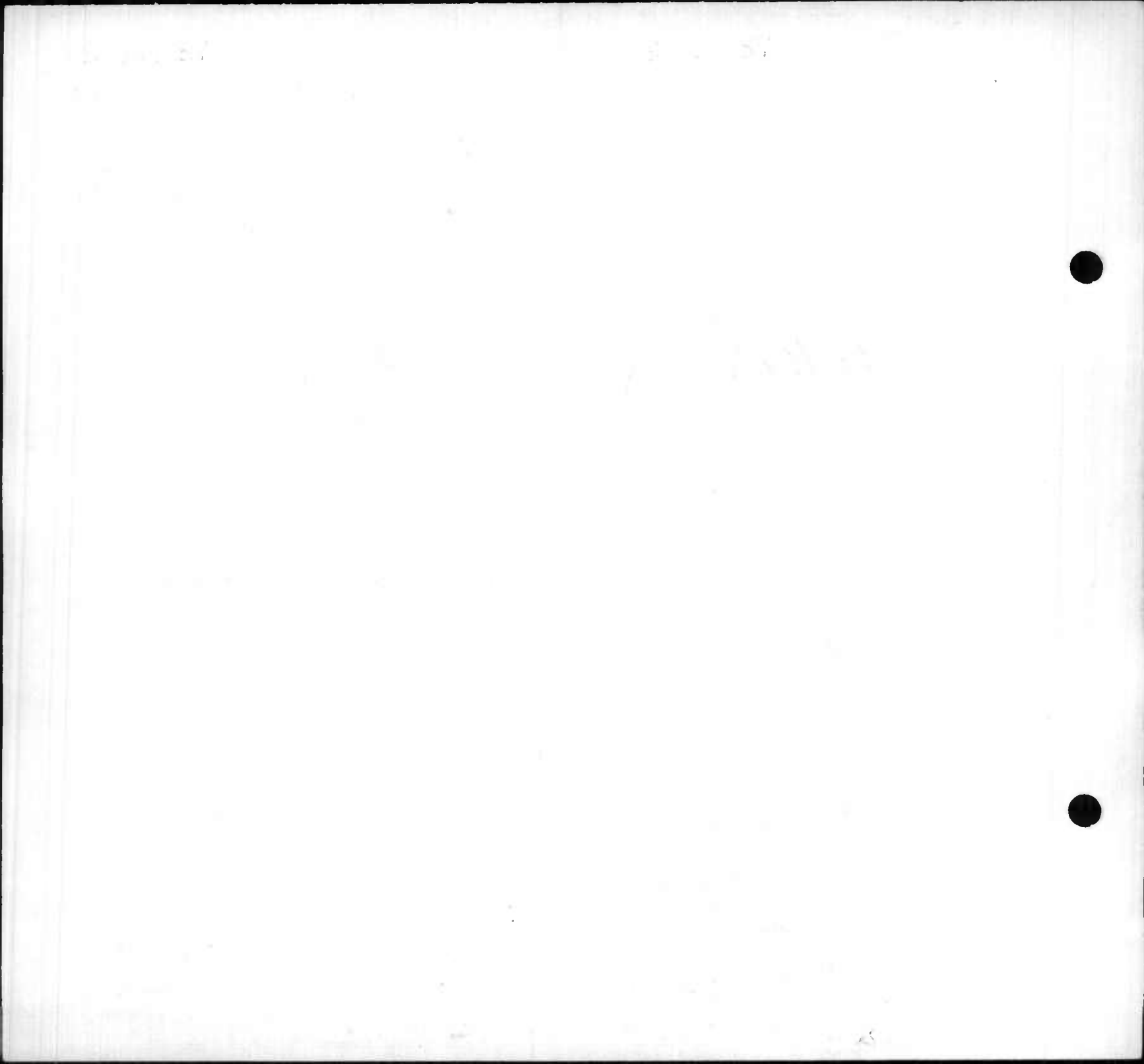
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02821
T-460 BIRTH NO. 72-03382 72 02821 1. NAME OF DECEASED (Type or Print) <i>Baby Girl Tyler</i>		2. DATE AND HOUR OF DEATH <i>March 10, 1972 1:45 P M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University of Maryland Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1621 N. Calvert St</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/4/72</i>	9. AGE (In years last birthday) <i>0</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>-</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>-</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>Eskenridge</i>		14. MOTHER'S MAIDEN NAME <i>Pauline Tyler Parker</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT ADDRESS <i>-</i>
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C)	
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>-</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>-</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>
22. I certify that (I) (this hospital) attended the deceased from <i>3/6</i> 19 <i>72</i> to <i>3/10</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>3/10</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Kusuma Pruksapong M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/10/72</i>
23C. PHYSICIAN'S NAME (Type) <i>KUSUMA PRUKSAPONG M.D.</i>		23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>3-20-72</i>		24B. DATE		24C. NAME of CEMETERY or CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 22 1972</i>		
25B. NAME OF REGISTRAR <i>Robert E. Tyler, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHD</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

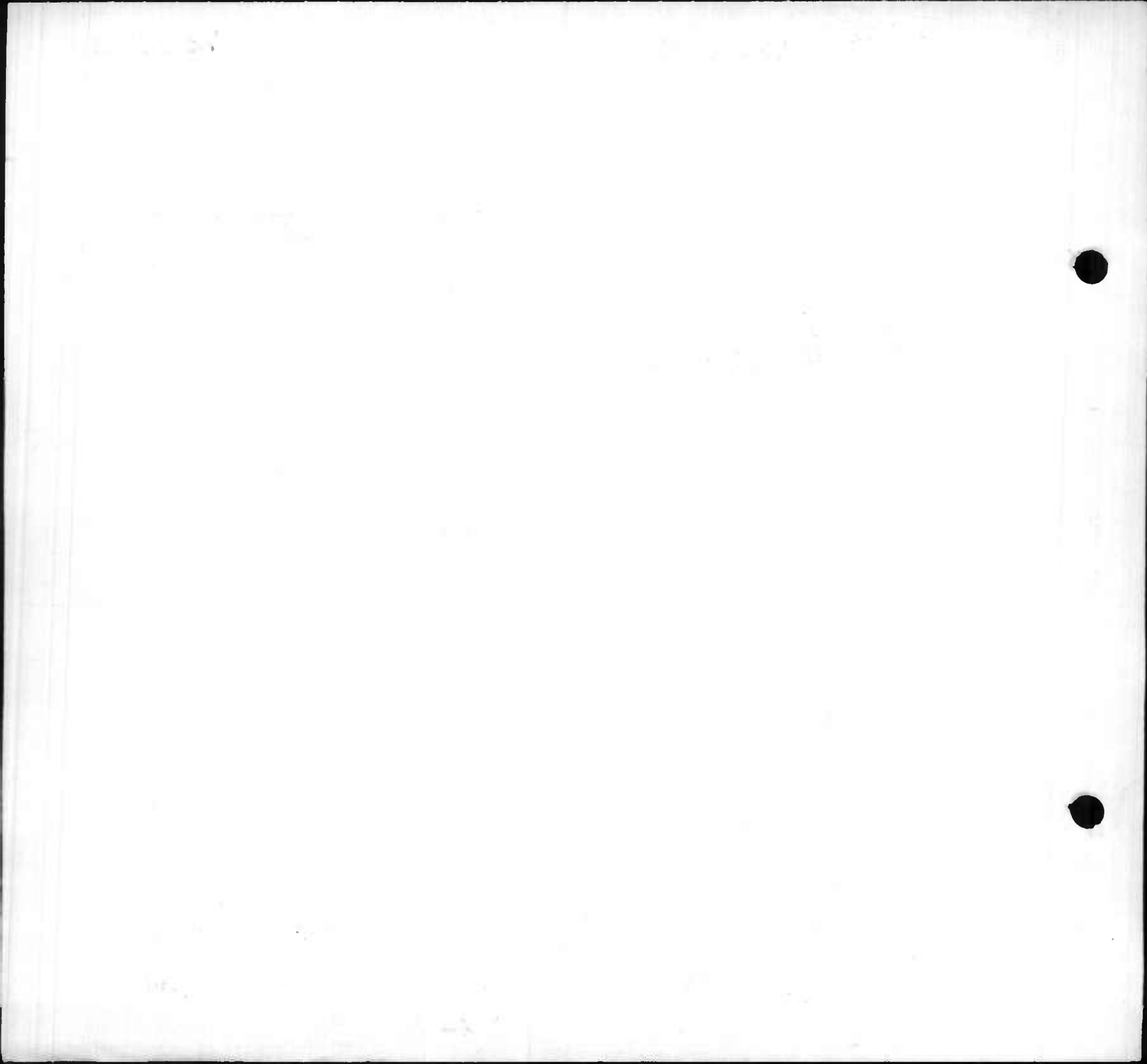
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02822</p>	
<p>BIRTH NO. 72-0364-72 02822</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Balt. Md B. COUNTY 1303</p>	
<p>1. NAME OF DECEASED (Type or Print) Baby girl Spencer</p>		<p>2. DATE AND HOUR OF DEATH March 12, 1972 11:40 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital</p>		<p>C. CITY OR TOWN Balt. Md D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 2214 Kenton Pl.</p>	
<p>5. SEX Female</p>	<p>6. RACE Negro</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 3/12/72</p>
<p>9. AGE (In years last birthday) -</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>	<p>11. BIRTHPLACE (State or foreign country) -</p>
<p>12. CITIZEN OF WHAT COUNTRY? -</p>		<p>13. FATHER'S NAME William</p>	
<p>14. MOTHER'S MAIDEN NAME Connelia Spencer</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -</p>	
<p>16. SOCIAL SECURITY NO. -</p>		<p>17. INFORMANT ADDRESS -</p>	
<p>18. 778.21</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE Respiratory failure</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Premature</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Disseminated Intravascular Coagulation</p>	
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -</p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>	
<p>19A. DATE OF OPERATION 3/12/72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -</p>	
<p>20A. AUTOPSY? (Yes or No) yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? -</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 3/12/72 19 3/12/72 19 that (I) (we) last saw the deceased alive on 3/12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Kusuma Pruksapong M.D.</p>		<p>23B. DATE SIGNED 3/12/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) KUSUMA PRUKSAPONG M.D.</p>		<p>23D. ADDRESS ANATOMY BOARD OF MARYLAND</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 3-20-72</p>		<p>24B. DATE 3-20-72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL</p>		<p>24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972</p>		<p>25B. NAME OF REGISTRAR John E. ...</p>	
<p>25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD</p>		<p>25D. ADDRESS -</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

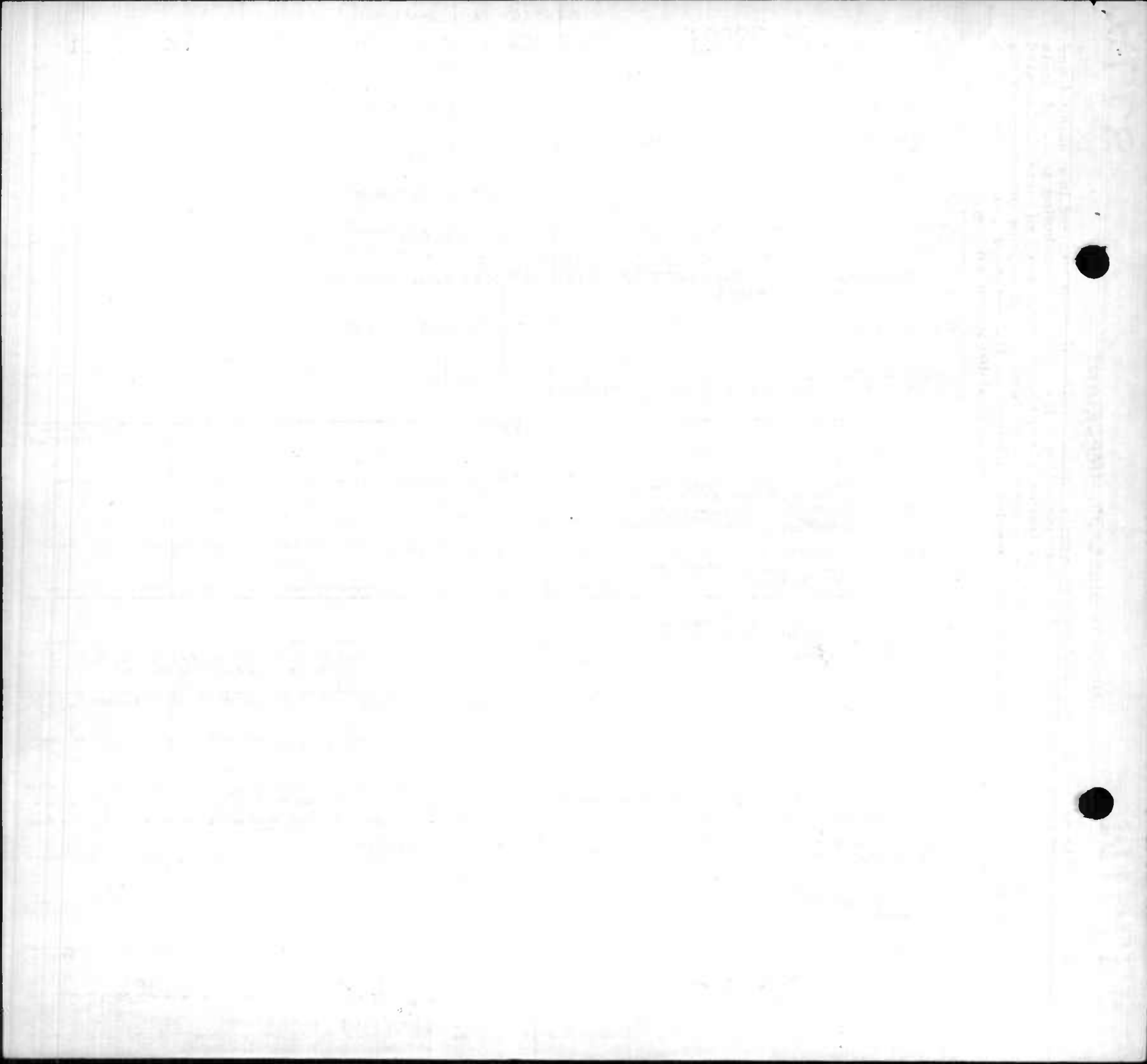
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02823	
7-512 BIRTH NO. 72-03335-02823				2. DATE AND HOUR OF DEATH March 6, 1972 6.00 A.M.			
1. NAME OF DECEASED (Type or Print) THOMPSON, BABY BOY				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 1604 B. COUNTY		5. CITY OR TOWN Baltimore		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
7. STREET AND NUMBER 730 N. Monmouth Street		8. DATE OF BIRTH 3/1/72		9. AGE (in years last birthday) 0		10. UNDER 1 Yr. Months: Days: Hours: Min. 6	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Doraine Leona E. Bowman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (If stating the UNDERLYING CONDITION lost). Anencephaly				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/1/72</u> to <u>3/6/72</u> that (I) (we) last saw the deceased alive on <u>3/6/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kusuma Praksapong M.D.				23B. DATE SIGNED 3/6/72		23C. PHYSICIAN'S NAME (Type) KUSUMA PRAKSAPONG M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-20-72		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR'S ADDRESS MORTUARY SERVICE - BCND			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 02824</u> 4	
BIRTH NO. <u>D-620 72 02824</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>DWOREK BOY</u>		2. DATE AND HOUR OF DEATH <u>3/5- 1:10 PM 72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South BALTO. Gen. Hosp.</u> <u>3001 S. HANOVER ST.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2403</u>	
5. SEX <u>M</u>		6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>3-5-72</u>		9. AGE (In years last birthday) <u>1</u> 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>W. J. Dwork</u>		14. MOTHER'S MAIDEN NAME <u>Beverly Elliott</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <u>776.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity (851 gram)</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory Distress Syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/5 12:08 PM</u> 19 <u>72</u> to <u>3/5 1:10 PM</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/5</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Dr. Ante Gragic</u>		23B. DATE SIGNED <u>3/5 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR ANTE GRAGIC</u>		23D. ADDRESS <u>S.B.C.H.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-20-72</u>	
24C. NAME OF CEMETERY		24D. NAME OF REGISTRAR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
MAR 22 1972		JOHNS HOPKINS MEDICAL SCHOOL	
VS 150-REV. 1/1/68		MORTUARY SERVICE - BCED	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		REG. NO. 72 02825	
7-600		72 02825	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
STELLA TERRY		SUNDAY MARCH 19, 1972 8:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION MIDTOWN NURSING HOME 808 ST. PAUL STREET		A. STATE MARYLAND B. COUNTY 1102	
		C. CITY OR TOWN BALTIMORE	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1225 N. CHARLES STREET 21202	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 17 1915
		9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY OFFICE	11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK
		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME MORRIS ALDRICH		14. MOTHER'S MAIDEN NAME HANNAH COHEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 062-09-5988	17. INFORMANT ADDRESS RIVERSIDE CHAPELS, 180 W. 76th ST. NEWYORK1002
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma Lung & Brain ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma Lung & Brain (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr ?	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/17 19 72 to 3/19/72 19 72 that (I) (we) last saw the deceased alive on 3/18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph S. Blum		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 3/19/72
23C. PHYSICIAN'S NAME (Type) DR JOSEPH S. BLUM		23D. ADDRESS 1115 N. CALVERT STREET, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL/BURIAL	24B. DATE 3/21/72	24C. NAME OF CEMETERY or CREMATORY CEDAR PARK	24D. LOCATION (City, town, or county) (State) PARAMUS, N. J.
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS 6010 REISTERSTOWN RD.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-216		72 02826		BALTIMORE CITY HEALTH DEPARTMENT		72 02826	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOCHBERG, IDEL				2. DATE AND HOUR OF DEATH 18 th MARCH 1972 6-15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTIMORE 42				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3408 JANELLEN DRIVE #21208			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 20 1908	9. AGE (In years last birthday) 63	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		11. BIRTHPLACE (State or foreign country) RUSSIA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HYMAN AARON HOCHBERG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-32-1005		17. INFORMANT MR. NORMAN HOCHBERG, 4 WHISPERWOOD CT. #21208			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARDIO-PULMONARY FAILURE (This does not mean the mode of dying, but the health condition, or conditions, or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, EXAMINER, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). H C her				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 3-15-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE CLIP AUSTIN MOORE PROSTHESIS		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 3-15-72		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N. H.		21C. WHERE DID INJURY OCCUR? 4601 Paul Mall Rd		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 3-15-72		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fall			
22. I certify that (I) (this hospital) attended the deceased from 3/17/72 1972 to 3/18/72 1972 that (I) (we) last saw the deceased alive on 3/18/72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 3/18/72		23C. PHYSICIAN'S NAME (Type) Dr. Saleen	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-19-72		24C. NAME OF CEMETERY or CREMATORY SHOMREI ADATH		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	

1. The first part of the report is a summary of the work done during the past year.

2. The second part is a detailed account of the experiments conducted.

3. The third part is a discussion of the results obtained.

4. The fourth part is a conclusion of the work done during the past year.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of errata.

11. The eleventh part is a list of acknowledgments.

12. The twelfth part is a list of dedications.

13. The thirteenth part is a list of prefaces.

14. The fourteenth part is a list of contents.

15. The fifteenth part is a list of indexes.

16. The sixteenth part is a list of appendices.

17. The seventeenth part is a list of footnotes.

18. The eighteenth part is a list of errata.

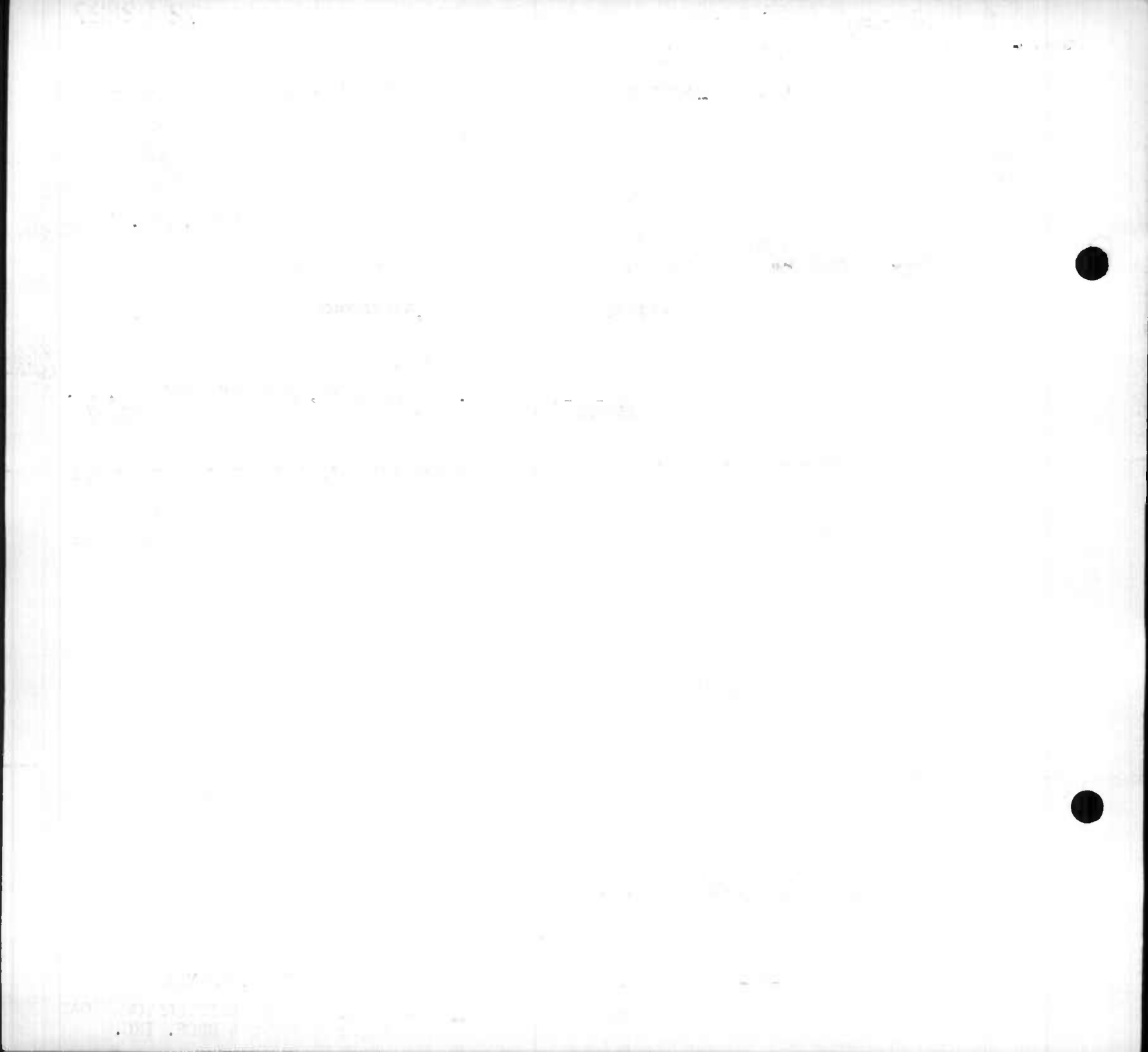
19. The nineteenth part is a list of acknowledgments.

20. The twentieth part is a list of dedications.

21. The twenty-first part is a list of prefaces.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-530		72 02827		BALTIMORE CITY HEALTH DEPARTMENT		72 02827	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) STEPHEN G. XXXXXX RUND				2. DATE AND HOUR OF DEATH 3/17/72 1 4 10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2802			
5. SEX MALE		6. RACE WHITE XXXXXX		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-45	
9. AGE (in years lost birthday) 26		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10B. KIND OF BUSINESS OR INDUSTRY MEDICAL		11. BIRTHPLACE (State or foreign country) MD, BALTIMORE	
13. FATHER'S NAME WERNER RUND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-42-7096 XXXXXX		17. INFORMANT MRS. CECELIA RUND, 2842 GATEHOUSE DR, APT. A #21207 XXXXXX	
18. 03891 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH PULMONARY INSUFFICIENCY SEPSIS ACUTE RENAL FAILURE SEPSIS ? ETIOLOGY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days 15 days 10 days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/2/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophage-gastric reflux		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 3/13 19 72 to 3/17 19 72 that (I) (we) last saw the deceased alive on 3/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George M. Brouillet Jr MD				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) GEORGE M. BROUILLET JR MD				23D. ADDRESS UNIV. OF MARYLAND HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-19-72		24C. NAME OF CEMETERY or CREMATORY NEW HAR SINAI		24D. LOCATION (City, town, or county) (State) OWINGS MILLS, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR John E. Miller, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		25D. ADDRESS 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02828
BIRTH NO. H-621 72 02828		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-weight: bold;">LOUIS HIRSHFELD</div>		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> MARCH 17, 1972 10:15 A. M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION <div style="text-align: center; font-weight: bold;">SINAI HOSPITAL</div> </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE <div style="text-align: center; font-weight: bold;">MARYLAND</div> </div> <div> B. COUNTY </div> </div>		
5. SEX <div style="display: flex; justify-content: space-around;"> MALE WHITE </div>		6. RACE 		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-weight: bold;">MERCHANT</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-weight: bold;">RETAIL</div>		
11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-weight: bold;">RUSSIA</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-weight: bold;">USA</div>		
13. FATHER'S NAME 		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-weight: bold;">TOBA ?</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center; font-weight: bold;">NO</div>		16. SOCIAL SECURITY NO. 		
17. INFORMANT 		ADDRESS <div style="text-align: center; font-weight: bold;">MR. WILLIAM HIRSHFELD, 3604 BARBERRY CT. #2120</div>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center; font-weight: bold;">ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. </div>		CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> (A) IMMEDIATE CAUSE <div style="text-align: center; font-weight: bold;">Cerebrovascular Accident</div> </div> <div> DUE TO, OR AS A CONSEQUENCE OF: </div> </div> <div style="display: flex; justify-content: space-between;"> <div> (B) <div style="text-align: center; font-weight: bold;">Arteriosclerosis</div> </div> <div> DUE TO, OR AS A CONSEQUENCE OF: </div> </div> <div style="display: flex; justify-content: space-between;"> <div> (C) </div> <div> </div> </div>		
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		
20A. AUTOPSY? (Yes or No) 		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 		21E. INJURY OCCURRED <div style="display: flex; justify-content: space-around;"> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div>		
21F. HOW DID INJURY OCCUR? 				
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> 1952 to <u>3/17</u> 1972 , that (I) (we) last saw the deceased alive on <u>3/17</u> 1972 and that in (my) (our) opinion death occurred on the date <u>3/17</u> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <div style="text-align: center; font-weight: bold;">Samuel Morrison</div>				23B. DATE SIGNED <div style="text-align: center; font-weight: bold;">3/17/72</div>
23C. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-weight: bold;">SAMUEL MORRISON</div>				23D. ADDRESS <div style="text-align: center; font-weight: bold;">11 E. CHASE STREET</div>
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center; font-weight: bold;">BURIAL</div>		24B. DATE <div style="text-align: center; font-weight: bold;">3-19-72</div>		
24C. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-weight: bold;">CHIZUK AMUNO (ARLINGTON)</div>		24D. LOCATION (City, town, or county) (State) <div style="text-align: center; font-weight: bold;">BALTIMORE, MARYLAND</div>		
25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center; font-weight: bold;">MAR 22 1972</div>		25B. NAME OF REGISTRAR 		
25C. FUNERAL DIRECTOR <div style="text-align: center; font-weight: bold;">SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</div>		ADDRESS 		

57 57 57

1000

1000

1000 1000 1000 1000

1000

1000

1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000

1000

1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

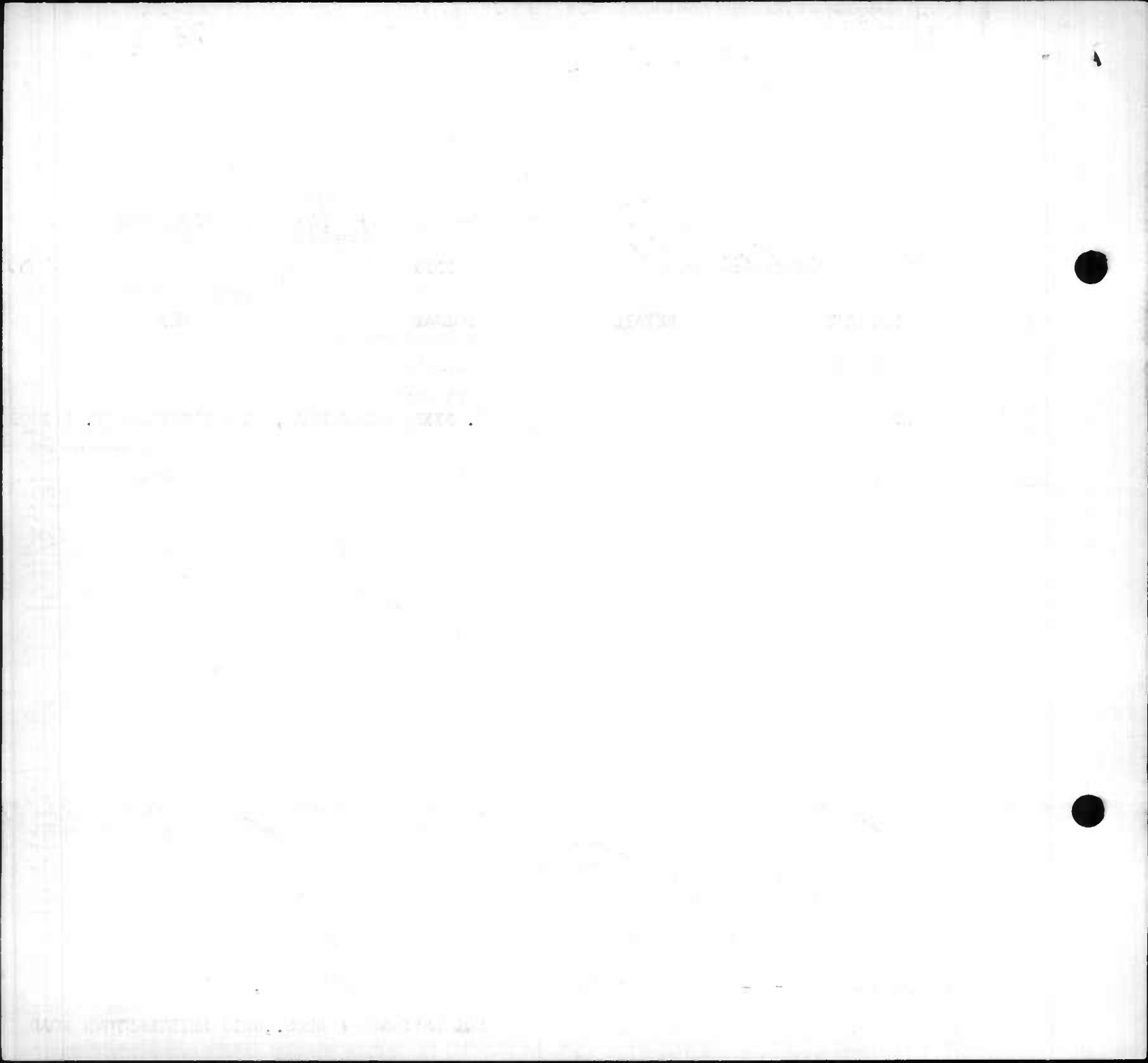
1000 1000 1000 1000

1000 1000 1000 1000

1000 1000 1000 1000

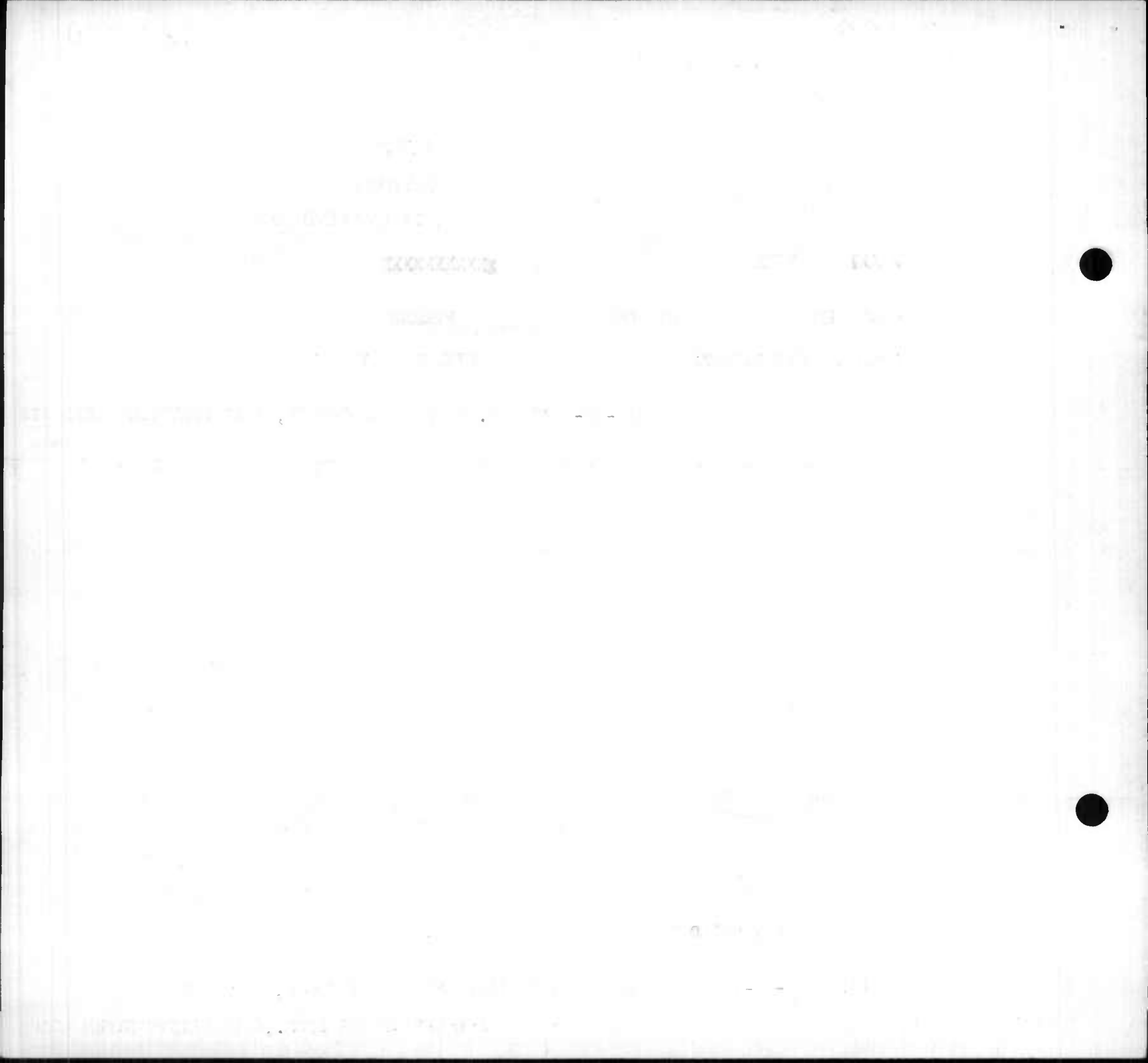
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



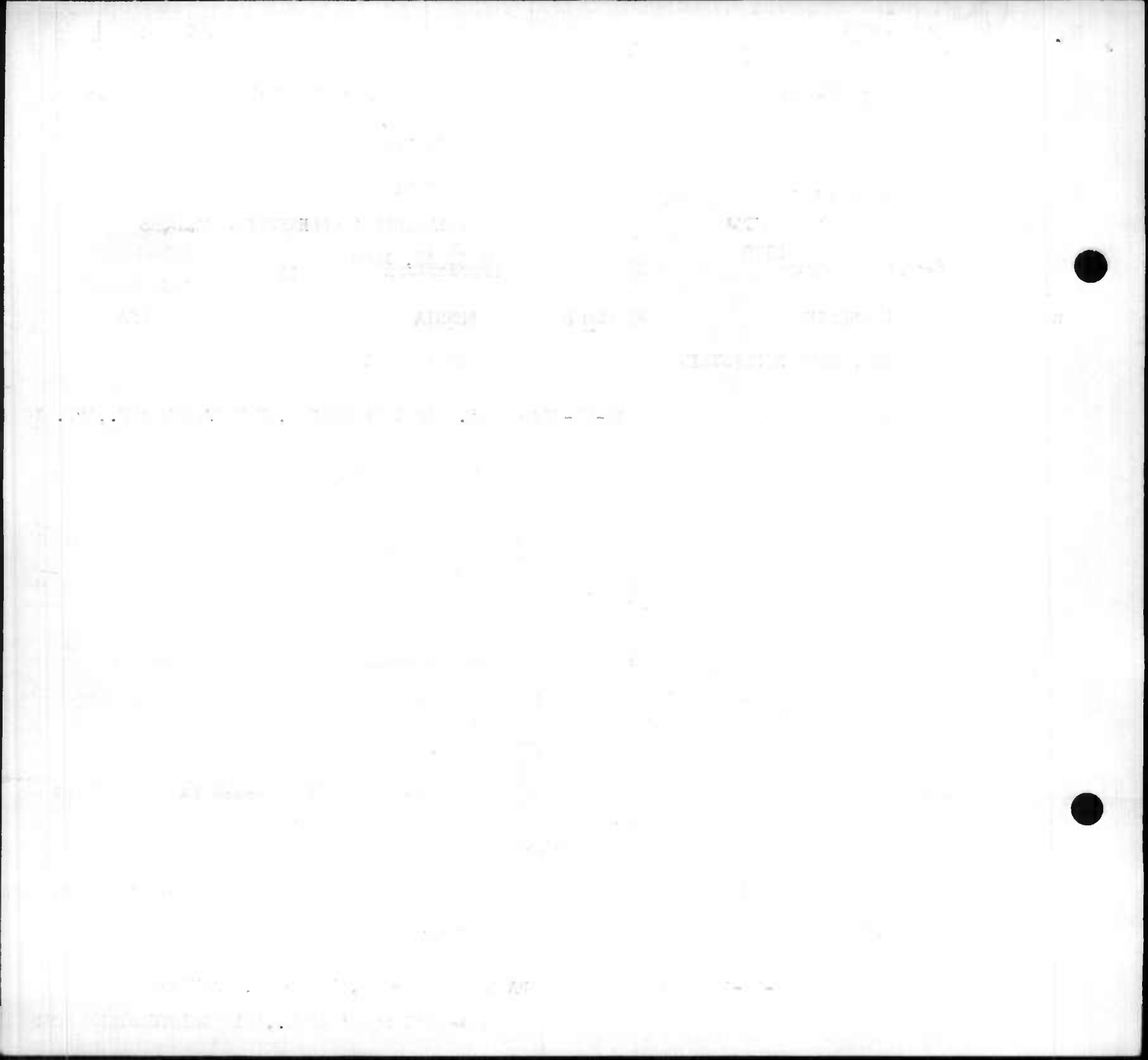
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02830	
BIRTH NO. 72 02830		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Brozowsky Anna		2. DATE AND HOUR OF DEATH March 18, 1972 4:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Balt. Inc.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4011 LABYRINTH ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXXXXXX	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ABRAHAM WOLF FISIMAN			
14. MOTHER'S MAIDEN NAME GITTEL ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-03-8519		17. INFORMANT ADDRESS MR. ABRAHAM BROZOWSKY, 4011 LABYRINTH ROAD #15			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.01 + 250.9 (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CVA DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension, diabetes DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days many years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 11, 1972 to March 18, 1972 that (I) (we) lost saw the deceased alive on March 22, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jack Pollock		23B. DATE SIGNED 3/18/72		23C. PHYSICIAN'S NAME (Type) JACK POLLOCK	
23D. ADDRESS SINAI		23E. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-20-72		24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. MAR 22 1972			
24F. NAME of REGISTRAR Robert E. Kelly, M.D.		24G. ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

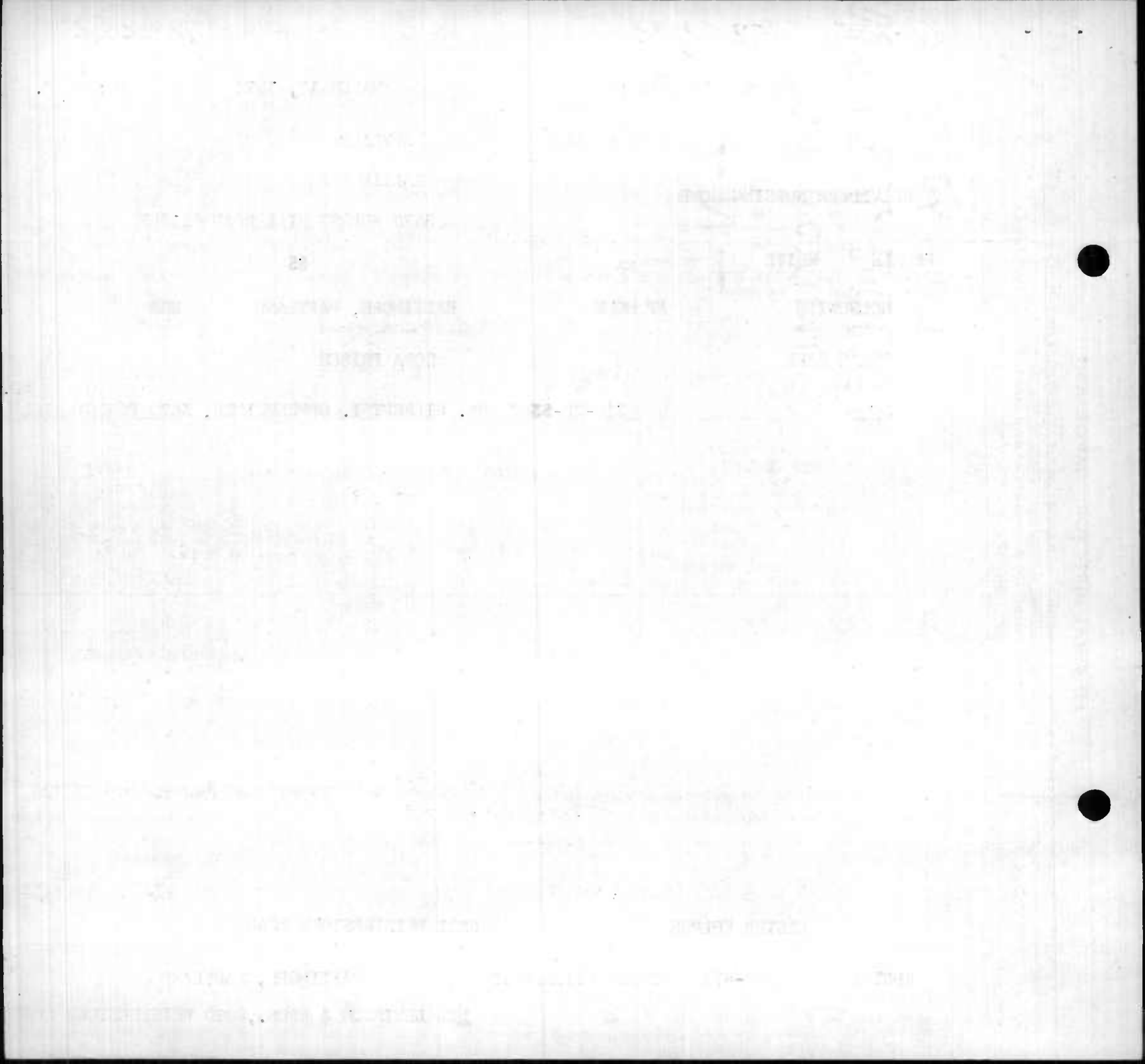
BALTIMORE CITY HEALTH DEPARTMENT				72 02831		72 02831	
72 02831				72 02831		72 02831	
1. NAME OF DECEASED (Type or Print) SOPHIA SOPHIA LEVIN				2. DATE AND HOUR OF DEATH March 18, 1972 5:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2717 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BELVEDERE & GREENSPRING AVENUES			
5. SEX Female	6. RACE WHITE Human	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15, 1889		9. AGE (In years last birthday) 82	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALEXANDER SAPERSTEIN				14. MOTHER'S MAIDEN NAME EMMA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-52-4349		17. INFORMANT ADDRESS MRS. NAOMI HENDERSON, 2709 HANSON AVE., APT. 1C			
18. 707.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Decubitus ulcer, deep DUE TO, OR AS A CONSEQUENCE OF:		one month	
				(C) malnutrition		3 month	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 12 19 68 to March 18 19 72 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 18 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) view the body after death.							
23A. SIGNATURE Young Hea Lew				23B. DATE SIGNED March 20, 1972			
23C. PHYSICIAN'S NAME (Type) YOUNG HEA LEW M.D.				23D. ADDRESS LEVINDALE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-20-72		24C. NAME OF CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, ROSEDALE, MARYLAND		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR John E. ...		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-155		72 02832		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02832	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		SOPHIA OPPENHEIMER				MARCH 17, 1972		10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 BELVEDERE NURSING HOME						A. STATE		B. COUNTY	
						MARYLAND		BALTO	
						C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
						BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER			
						3670 FOREST HILL ROAD #21207			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				AT HOME		BALTIMORE, MARYLAND		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
ISAAC BAER						DORA FRISCH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				219-20-5367		MR. GILBERT I. OPPENHEIMER, 3670 FOREST HILL RD.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i> <i>Septic</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12th</i> <i>12th</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>April 6</i> 1967 to <i>Mar 17</i> 1972, that (I) (we) last saw the deceased alive on <i>Mar 17</i> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
<i>Lester Kolman</i>						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		<i>Mar 18 1972</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
LESTER KOLMAN				6821 REISTERSTOWN ROAD					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		3/20-72		HEBREW FRIENDSHIP		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
MAR 22 1972				SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-520 72 02833				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02833	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) John Henry Hannahs			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH March 20, 1972 7:05 A. M.			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 528 South Ellwood Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 102			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1900	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Ess0 60		9. AGE (In years last birthday) 71		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John William Hannahs				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-4192		17. INFORMANT Mrs Catherine Hannahs		ADDRESS Same	
18. 412.414250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus						22 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1950 to March 20 1972 , that (I) (we) last saw the deceased alive on March 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Clarence W. LeDoux, M.D.</i>				23B. DATE SIGNED 3/20/72			
23C. PHYSICIAN'S NAME (Type) Clarence W LeDoux M.D.				23D. ADDRESS 3023 Eastern Ave Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME OF CEMETERY or CREMATORY Oaklawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Rebecca J. ...		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Baltimore, Md	

1-2-53

1-2-53

1-2-53

X

1-2-53

1-2-53

1-2-53

1-2-53

1-2-53

1-2-53

1-2-53

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-000		72 02834		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02834	
1. NAME OF DECEASED (Type or Print) Lucille Shea				2. DATE AND HOUR OF DEATH 3/20/72 17:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Pennsylvania B. COUNTY V 35			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue 21224				C. CITY OR TOWN Red Red Lion		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 44 East Avenue			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-39	9. AGE (In years last birthday) 32	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10B. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Hickman				14. MOTHER'S MAIDEN NAME Marion Sites			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 177-30-9335		17. INFORMANT ADDRESS BCH-Records 4940 Eastern Avenue Baltimore, Maryland		
18. 172.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Malignant Melanoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/21 19 72 to 3/20/1972 that (I) (we) last saw the deceased alive on 3/20/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H.S. Goldberg, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Type) H.S. Goldberg M.D.				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-72		24C. NAME OF CEMETERY OR CREMATORY Canadochly Cemetery		24D. LOCATION (City, town, or county) (State) Lower Windsor Township, Pa.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Blair, Mrs.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS Towson, Md. 21204	

RECEIVED - JAN 21 1964

Section Chief

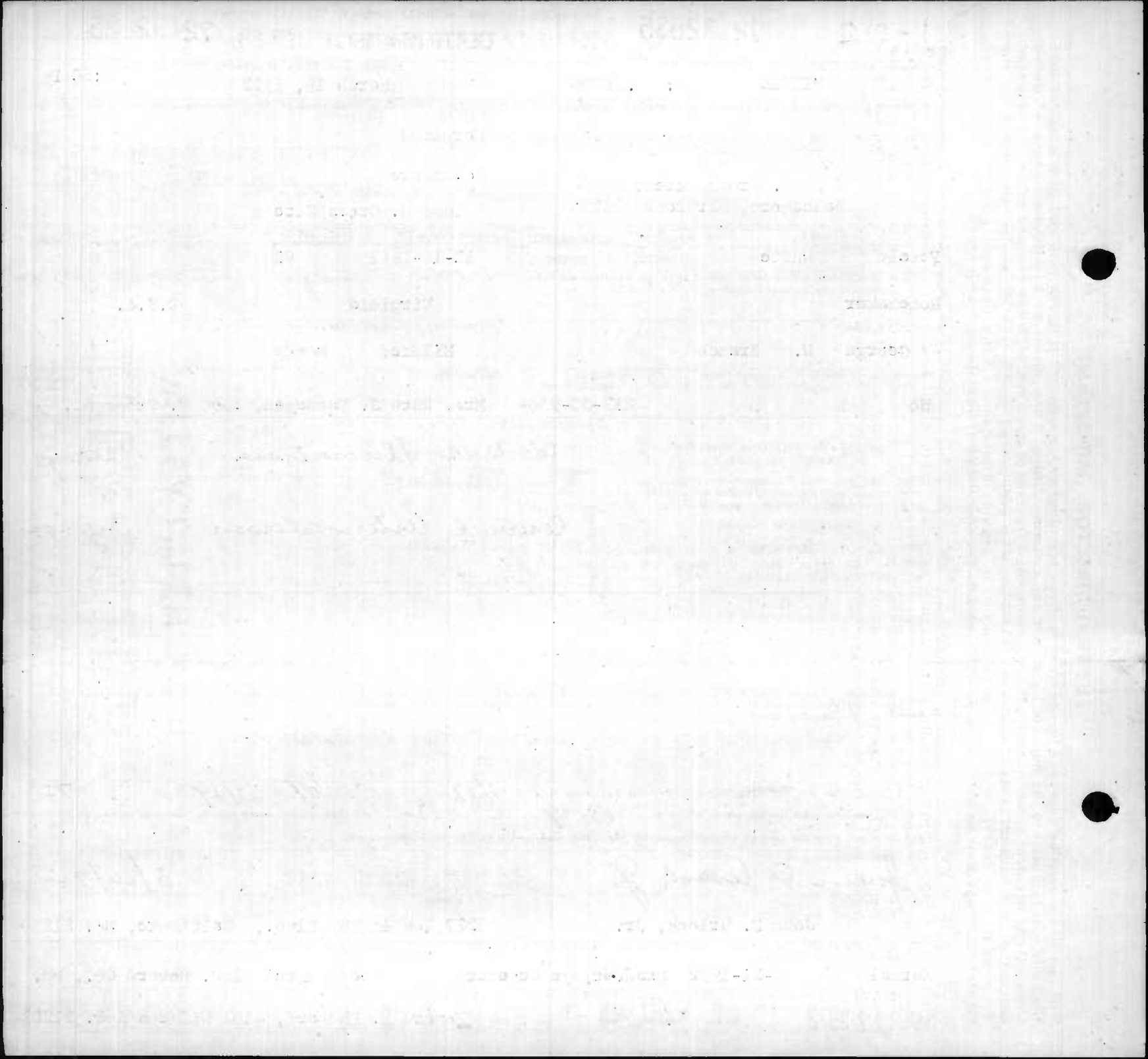
77-1-2013

2 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

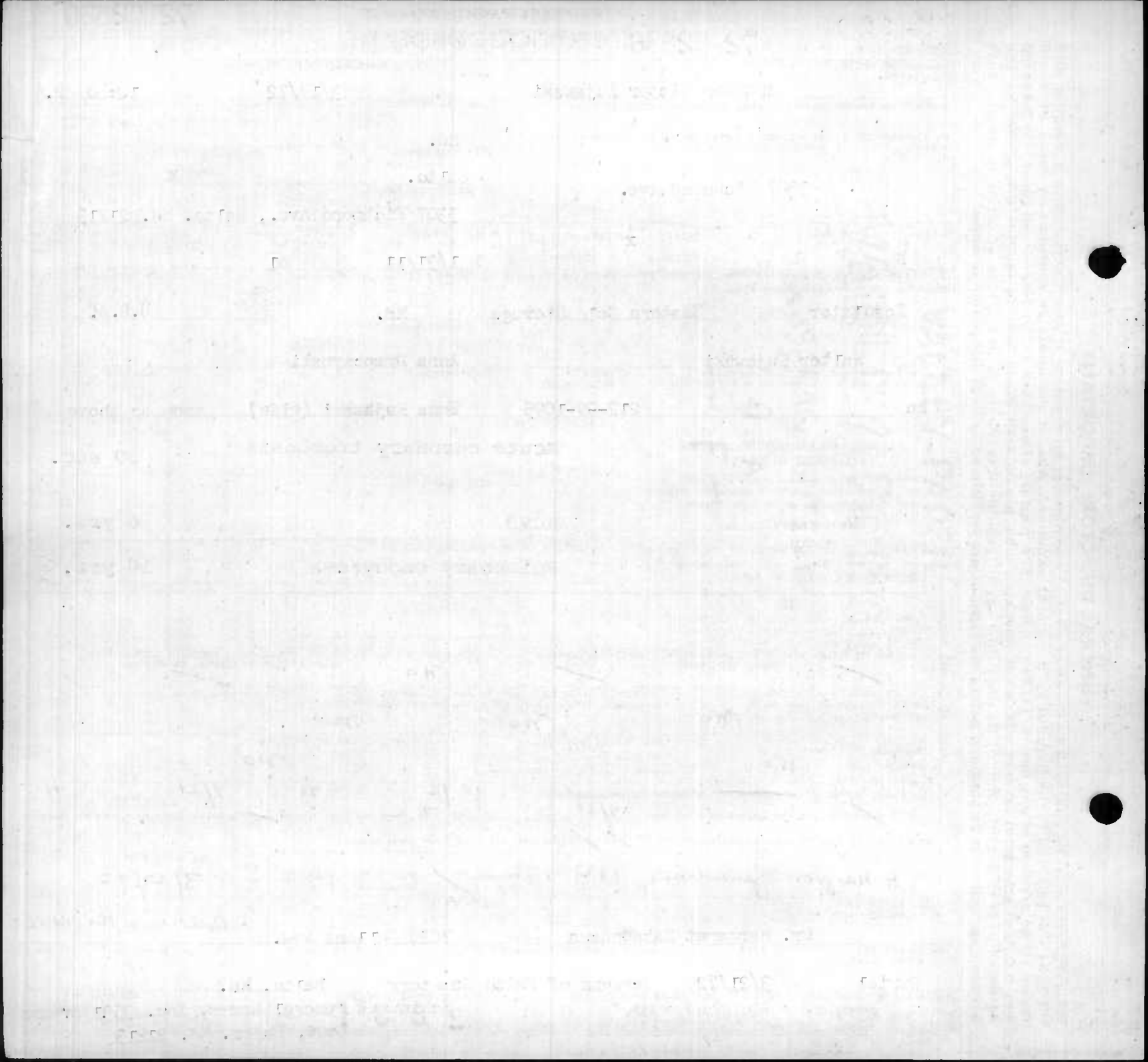
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02835
BIRTH NO. J-212		72 02835		
1. NAME OF DECEASED (Type or Print) MINNIE M. JACOBS		2. DATE AND HOUR OF DEATH March 19, 1972 4:50 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1006 W. Cross Street Baltimore, Maryland 21230		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1006 W. Cross Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-1881	9. AGE (In years last birthday) 90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Branch		
14. MOTHER'S MAIDEN NAME Mildred Woody		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-03-9564		17. INFORMANT ADDRESS Mrs. Ruth J. Hashagen, 1006 W. Cross St. 21230		
18. 4539 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslerhenio, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebral Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/12 1969 to 3/19 1972 , that (I) (we) last saw the deceased alive on 3/19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE John P. Urlock, Jr.		23B. DATE SIGNED 3/20/72		23C. PHYSICIAN'S NAME (Type) John P. Urlock, Jr.
23D. ADDRESS 1227 Washington Blvd., Baltimore, Md. 21230		24A. BURIAL CREMATION, REMOVAL (Specify) Nurial		
24B. DATE 3-21-1972		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co., Md.
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02836	
72 02836 CERTIFICATE OF DEATH				REG. NO. 72 02836	
1. NAME OF DECEASED (Type or Print) Anthony Victor Kujaewski				2. DATE AND HOUR OF DEATH 3/17/72 10:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3307 Richmond Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 833	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 7/31/11 9. AGE (In years last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insulator				11. BIRTHPLACE (State or foreign country) Md.	
10B. KIND OF BUSINESS OR INDUSTRY Eastern Cold Storage				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Kujaewski				14. MOTHER'S MAIDEN NAME Anna Drapczynski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-09-7095	
17. INFORMANT Emma Kujaewski (wife)				ADDRESS same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary thrombosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 sec.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACVD				6 yrs.	
(B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emphysema				10 yrs.	
(C) _____				_____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 9/27		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no	
22. I certify that (I) (this hospital) attended the deceased from 10/2 19 70 to 9/27 19 71 , that (I) (we) last saw the deceased alive on 9/27 19 71 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H. Margaret Zassenhaus, MD				23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Type) Dr. Margaret Zassenhaus				23D. ADDRESS 7028 Bellona Ave. Baltimore, Md. 2122	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery Balto. Md.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972			
25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR Schumnek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02837
D-200 72 02837		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) William Henry Dess, Sr.		2. DATE AND HOUR OF DEATH March 16, 1972 10:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3108 Cliftmont Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 841		
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3108 Cliftmont Ave., Balto., Md. 21213		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/96	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Manager		10B. KIND OF BUSINESS OR INDUSTRY Sheppard Elec. Co.		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Dess		
14. MOTHER'S MAIDEN NAME Susan Schwartzkopf		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		
16. SOCIAL SECURITY NO. 216-09-0367		17. INFORMANT Frances Dess (wife)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 162.1 I		CAUSE OF DEATH BRONCHOGENIC CARCINOMA G-8 mms.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 mms.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from January 1946 to March 16, 1972 , that (I) (we) last saw the deceased alive on 3-15, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE William L. Fearing		23B. DATE SIGNED 3-18-72		23C. PHYSICIAN'S NAME (Type) Dr. William L. Fearing
23D. ADDRESS 3025 Belair Road, Balto., Md. 21213		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3/20/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		
25B. NAME OF REGISTRAR Blair J. [illegible]		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto., Md. 21213		

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

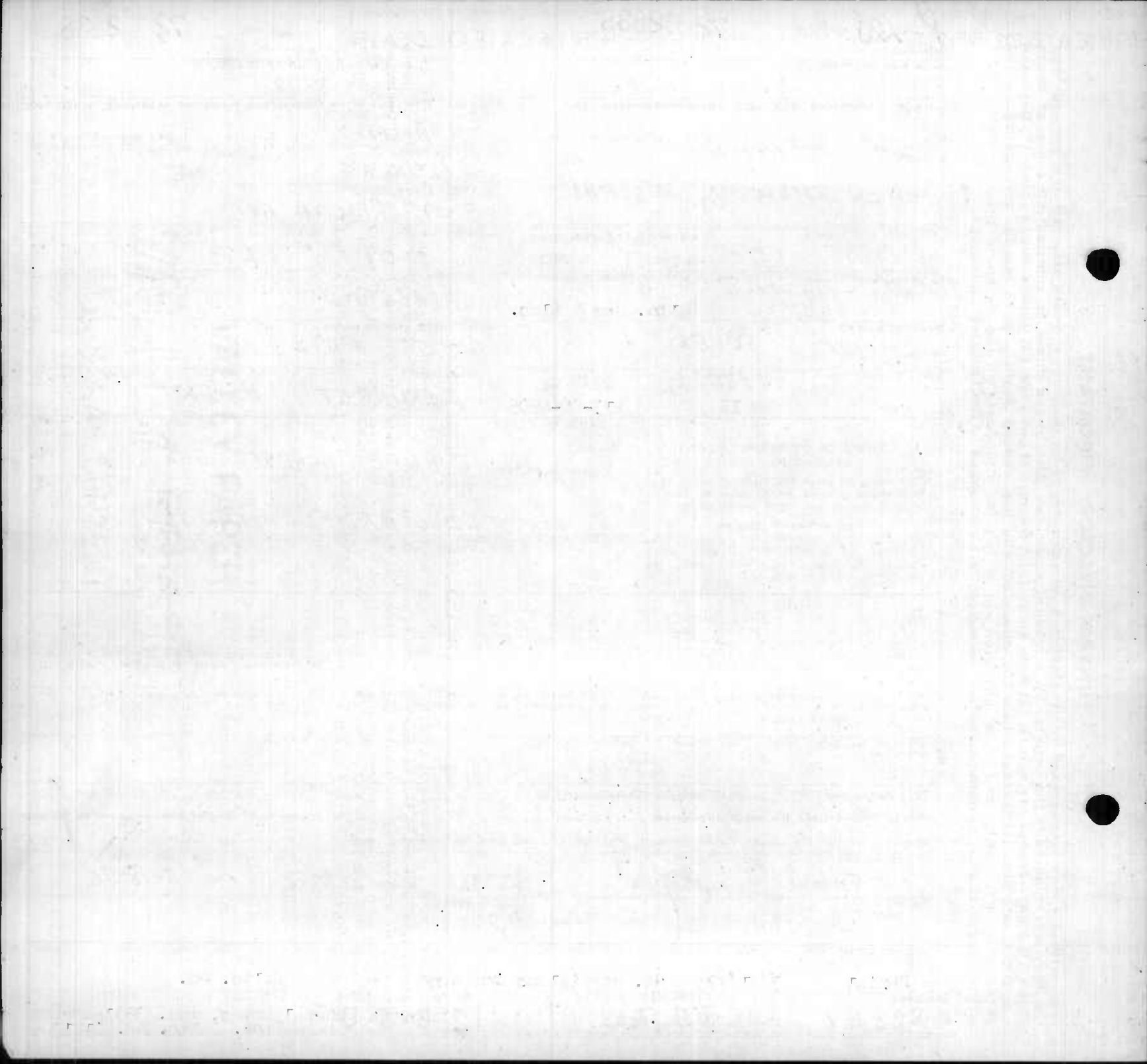
2033

2034

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

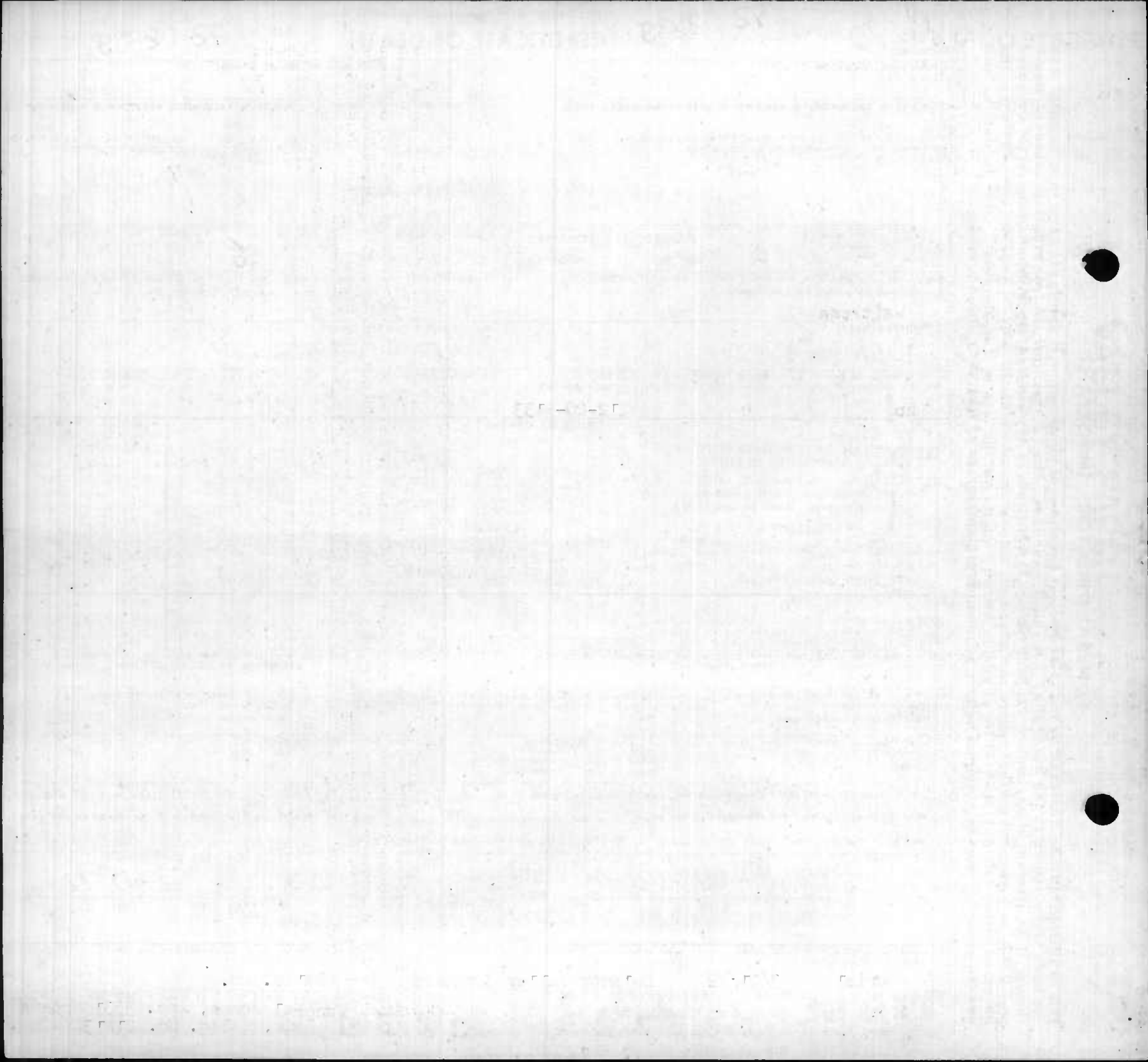
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02838</p>
<p>BIRTH NO. P-420</p>		<p>2. DATE AND HOUR OF DEATH 3-18-72 2:05 P.M.</p>
<p>1. NAME OF DECEASED (Type or Print) JOSEPH POLEK</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2633</p>
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL</p>		<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3209 RAMONA AVE</p>
<p>5. SEX M 6. RACE W</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 10-27-09 9. AGE (In years last birthday) 62</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORERMAN</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec.</p>
<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? AMERICAN</p>
<p>13. FATHER'S NAME MICHAEL POLEK</p>		<p>14. MOTHER'S MAIDEN NAME LOUISE KUTZ</p>
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II</p>		<p>16. SOCIAL SECURITY NO. 213-09-6905</p>
<p>17. INFORMANT MARGARET POLEK</p>		<p>ADDRESS</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH CARDIAC ARREST</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYOCARDIAL INFARCTION</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>
<p>19A. DATE OF OPERATION 3-10-72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from 3-15-72 to 3-18-72, that (I) (we) lost saw the deceased alive on 3-18-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		
<p>23A. SIGNATURE <i>Juan M. Calderon</i></p>		<p>23B. DATE SIGNED 3-18-72</p>
<p>23C. PHYSICIAN'S NAME (Type) JUAN H. CALDERON M.D.</p>		<p>23D. ADDRESS UMH</p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3/21/72</p>
<p>24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Balto. Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher</p>
<p>25C. FUNERAL DIRECTOR Schmunk Funeral Homes, Inc.</p>		<p>ADDRESS 3331 Brehms Lane, Balto. Md. 21213</p>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

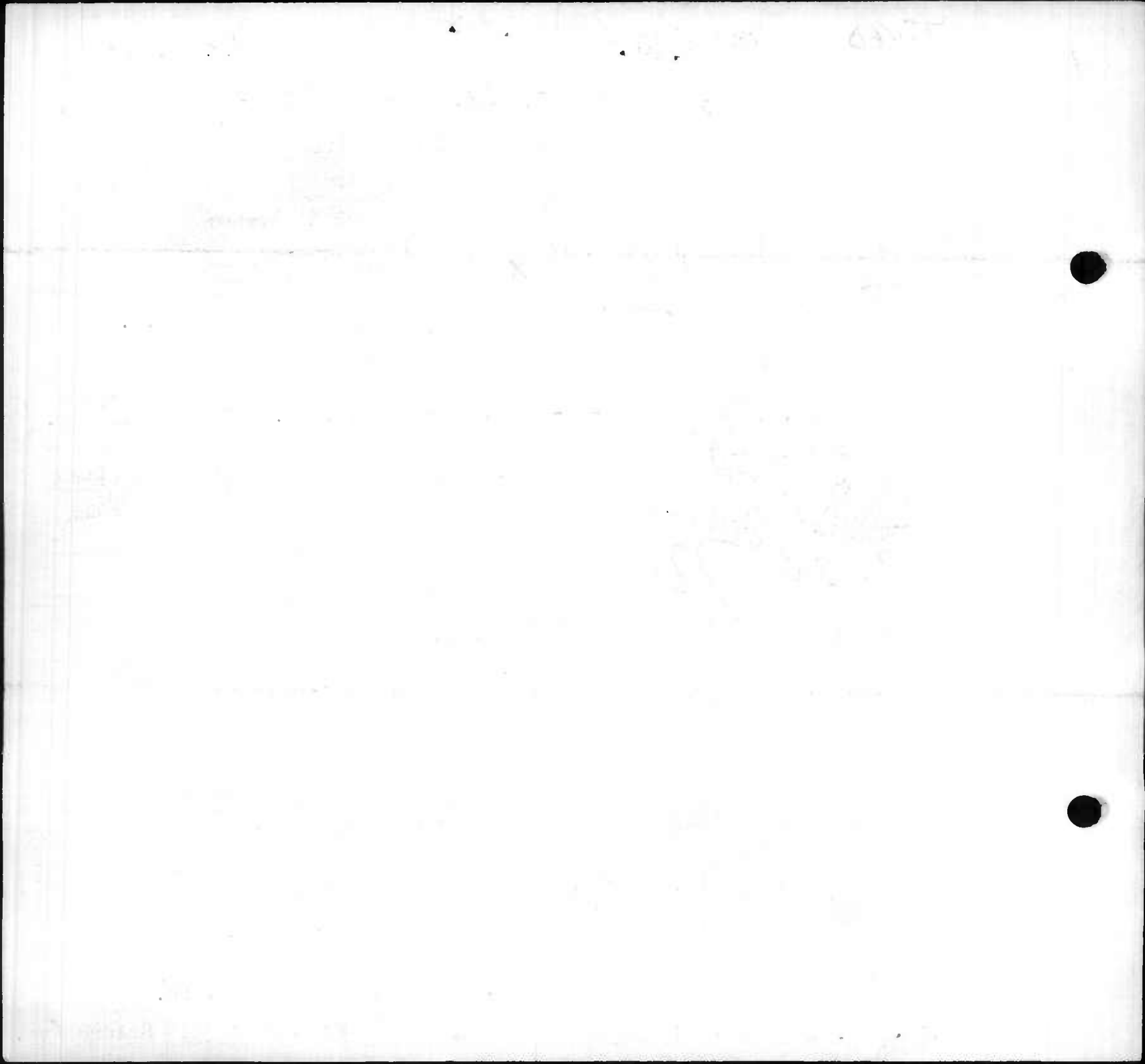
<div style="display: flex; justify-content: space-between;"> P-620 72 02839 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 72 02839 </div>			
1. NAME OF DECEASED (Type or Print) RITA PRICE		2. DATE AND HOUR OF DEATH 3-17-72 3:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2738	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1381 14TH AVENUE	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-14-25
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 46 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME JOHN JACKSON		14. MOTHER'S MAIDEN NAME AMELIA FISCHITTI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-20-9133	17. INFORMANT ADDRESS ROBERT B. PRICE SAKE
18. 450X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE PNEUMONIA II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY EMBOLI MITRAL VALVE DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3-7-72 to 3-17-72 , that (I) (we) last saw the deceased alive on 3-17-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Juan M. Calderon M.D. DEGREE			23B. DATE SIGNED 3-17-72
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.		23D. ADDRESS UMH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72	24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery
24D. LOCATION (City, town, or county) Balto. Md.		(State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Juan M. Calderon	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

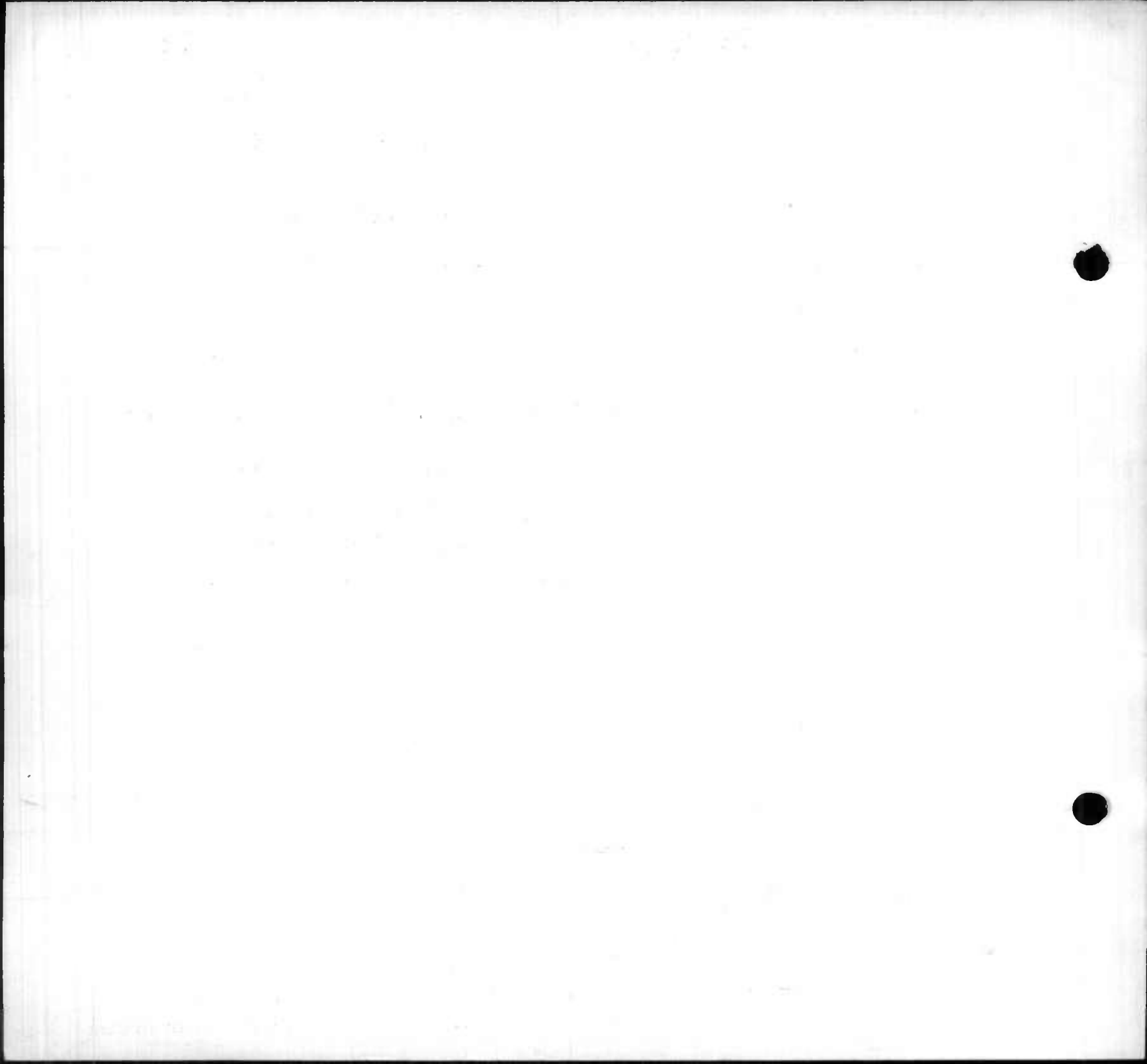
T-460		72 02840		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02840	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Taylor, James A. Sr.</u>			
2. DATE AND HOUR OF DEATH <u>03-16-72</u> <u>9:50 p.</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>XXXXXX Maryland</u> B. COUNTY <u>XXX</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 MARYLAND GENERAL HOSP</u>				C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2606 Maryland Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>02-04-10</u>	9. AGE (In years last birthday) <u>62</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. II</u>				16. SOCIAL SECURITY NO. <u>215-07-0910</u>		17. INFORMANT <u>James Taylor, Jr.</u> ADDRESS <u>21207 3820 Victoria Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY CAUSING DEATH CERTIFICATION APPROVED BY (This does not mean the mode of dying, e.g., heart attack, etc. It means the disease, injury or complication which caused death.) I, <u>—</u> MEDICAL EXAMINER. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Fractured Hip</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>alcoholism</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>2606 Md Ave 12-06</u>			
21D. TIME OF INJURY (APPROX.) <u>3 15 72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>fall</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>8-15</u> 19 <u>72</u> to <u>3-16</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3-16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Germond Crowley</u>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>CROWLEY</u>				23D. ADDRESS <u>Maryland Gen'l Hosp-</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/22/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gettysburg Vet. Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Gettysburg, Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>Donovan</u>		ADDRESS <u>Funeral Home 3818 Roland Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02841</u>	
M-450		72 02841		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Mallon (Malloun)</u>		2. DATE AND HOUR OF DEATH <u>8/20/72</u> <u>1:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Century Nursing Home</u> <u>102 N. Paca Street</u>		C. CITY OR TOWN <u>Rosedale</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>1603 Rosewick Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-92</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Lanahan</u>		14. MOTHER'S MAIDEN NAME <u>Mary O'Keefe</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 26 6654</u>		17. INFORMANT <u>Mary C. Klein</u> ADDRESS <u>1304 Rosewick Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH I <u>Cardiorespiratory Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic CUM</u> (B) <u>Kimmelstiel-Wilson Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>8/20/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>65</u> to <u>Mar 20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Mar 20</u> 19 <u>72</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did not</u> (did not) view the body after death.					
23A. SIGNATURE <u>William Appleford</u>		23B. DATE SIGNED <u>8/20/72</u>		23C. PHYSICIAN'S NAME (Type) <u>William Appleford</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-23-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24F. FUNERAL DIRECTOR <u>Ernest H. 1211 Chesaco Avenue</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



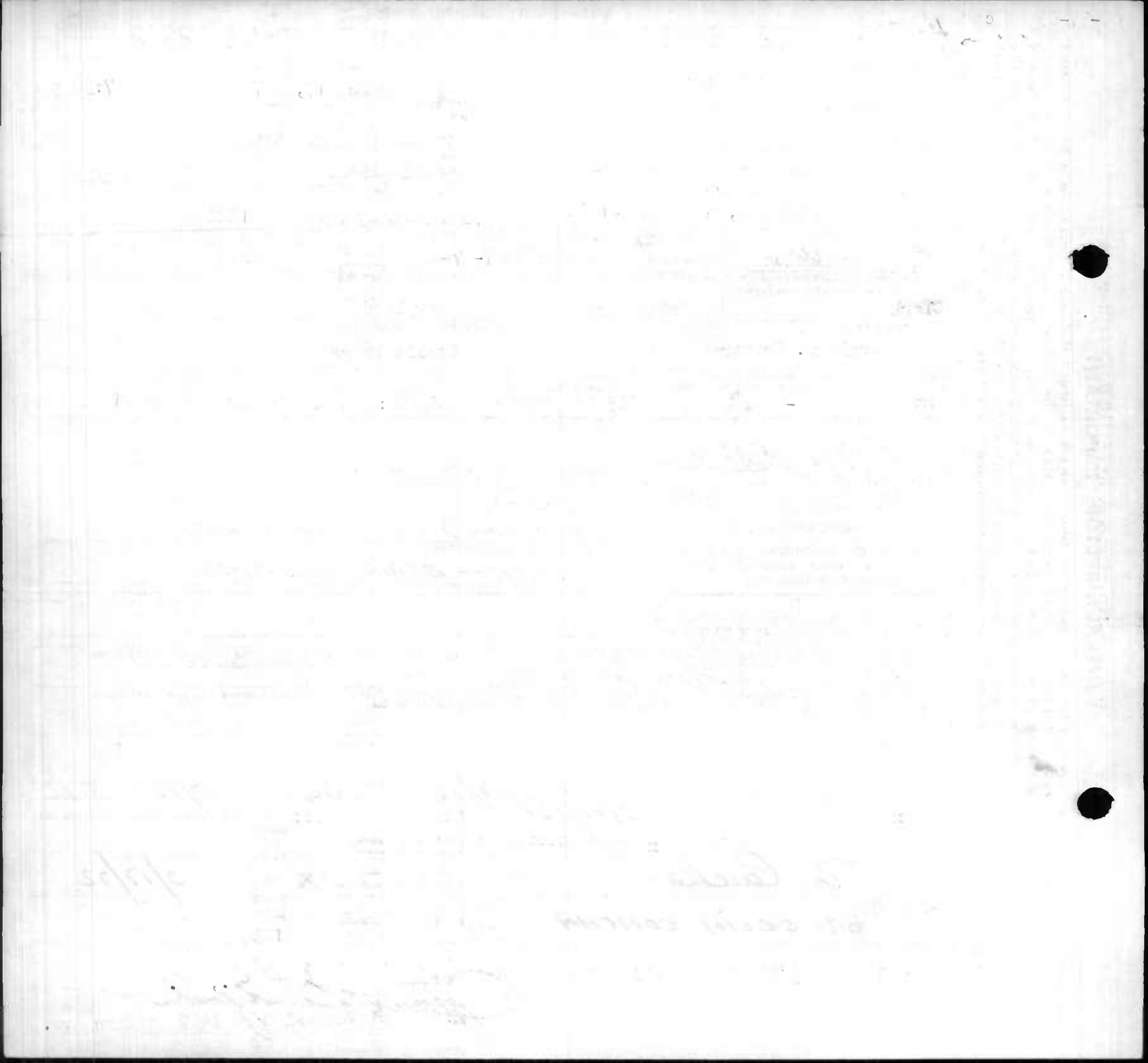
CERTIFICATE OF DEATH

REG. NO. 72 02842

BIRTH NO. 72 02842		2. DATE AND HOUR OF DEATH March 17, 1972 7:30 p.m.	
1. NAME OF DECEASED (Type or Print) Ruby Hancock		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. SEX Female 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7-27-28 9. AGE (In years last birthday) 43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10B. KIND OF BUSINESS OR INDUSTRY Hobby Shop		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Argle L. Crabtree		14. MOTHER'S MAIDEN NAME Stella Myers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215 26 6426	
17. INFORMANT BCH RECORDS: 4940 Eastern Avenue 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 h.	
19A. DATE OF OPERATION 3/17/72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CEREBRAL ANEURYSM		20A. AUTOPSY? (Yes or No) NO. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/17/72 1972 to 3/17 1972 that (2) (we) lost saw the deceased alive on 3/17/72 19 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.			
23A. SIGNATURE Dr. Concha.		23B. DATE SIGNED 3/17/72	
23C. PHYSICIAN'S NAME (Type) DR. SELIM CONCHA		23D. ADDRESS 4940 Eastern Avenue 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72	
24C. NAME of CEMETERY or CREMATORY Holly Hill Memorial Gardens		24D. LOCATION (City, town, or county) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Prizdzinski Funeral Home		ADDRESS 1407 Eastern Ave.	

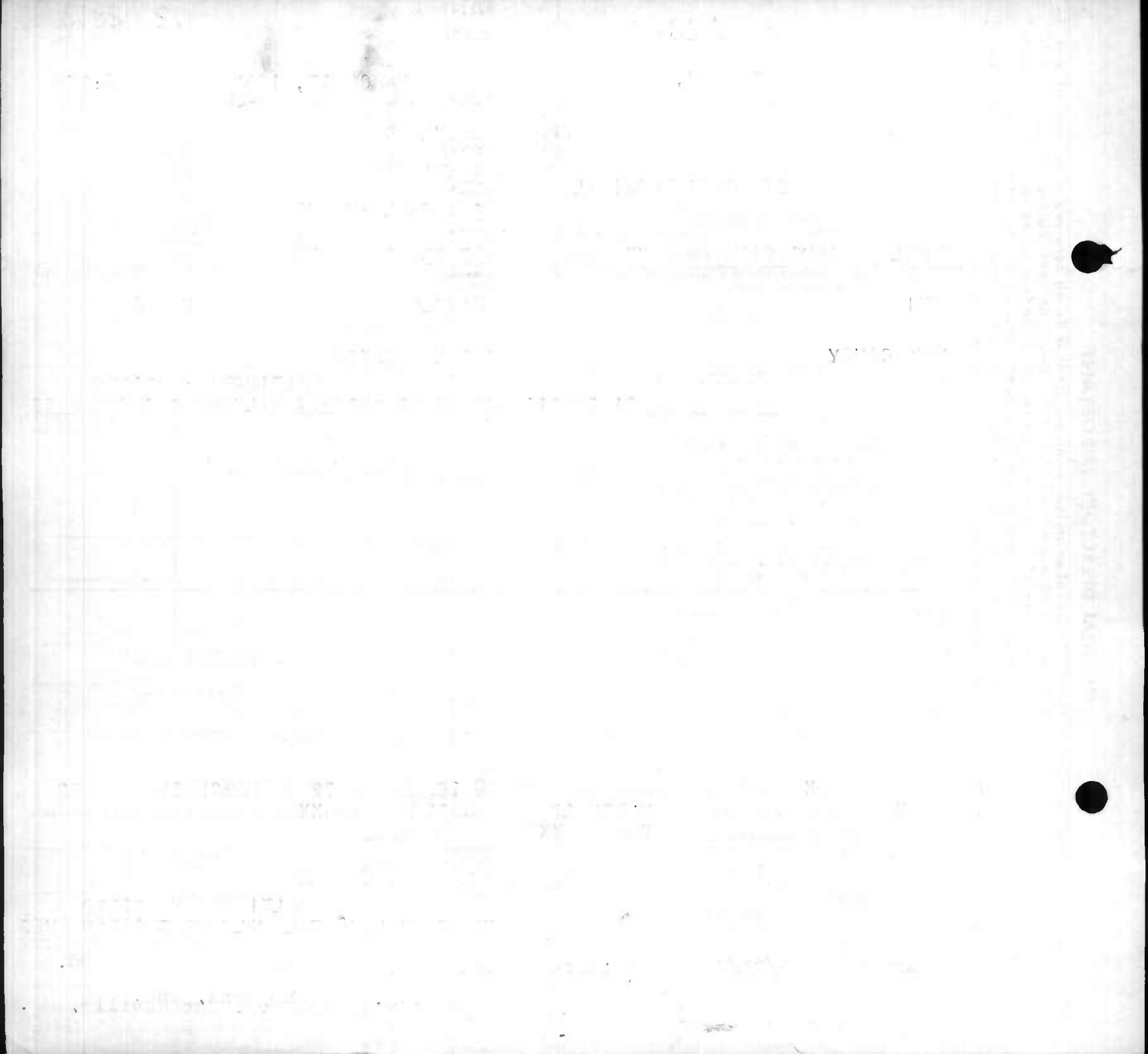
Released On Approval by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		72 02843		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02843	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				CHANEY, EDNA MAE		2. DATE AND HOUR OF DEATH MARCH 17, 1972 6:25P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO 5300			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3 ROGNEI AVENUE							
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 13 01	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME JOHN CAVEY			14. MOTHER'S MAIDEN NAME CECELIA UPTON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. 219362311		17. INFORMANT ADDRESS BALTIMORE MD 21229 ST AGNES RECORDS WILKENS & CATON AVES		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH C.V.A. (Basilar thrombosis)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. a.s.c.v.d.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:				old Myocardial infarct			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1X) (this hospital) attended the deceased from MARCH 15 1972 to MARCH 17 1972 that (X) (we) last saw the deceased alive on MARCH 17 1972 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.							
23A. SIGNATURE J.J. Mol				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/3/12/72	
23C. PHYSICIAN'S NAME (Type) J.J. Mol				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/21/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR R. E. E. E. E.		25C. FUNERAL DIRECTOR MacNabb Sons, Inc.		ADDRESS 2301 Frederick Ave. Catonsville, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-130 72 02844		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 02844 REG. NO.	
1. NAME OF DECEASED (Type or Print) WILLIE ESTHER BOBBITT			2. DATE AND HOUR OF DEATH MARCH 19, 1972 1:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5108 Greenwich Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2854 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5108 Greenwich Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1896	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Avery L. Graybeal			14. MOTHER'S MAIDEN NAME S. Catherine Clark		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-12-1460	17. INFORMANT David T. Bobbitt ADDRESS 1345 N. Rolling Rd. Catonsville, Md.		
18. 156.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) Carcinoma of Gall Bladder. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACVD			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 19, 1953 to Mar. 19, 1972 that (I) (we) last saw the deceased alive on Mar. 19, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp, M.D.			23B. DATE SIGNED 3-20-72		23C. PHYSICIAN'S NAME (Type) Harry L. Knipp, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Transit		24B. DATE 3/22/72		24C. NAME OF CEMETERY or CREMATORY Rosewood Cemetery	
24D. LOCATION Lewisburg, West Virginia		24E. ADDRESS 4116 Edmondson Ave. Baltimore, Md.		24F. ADDRESS Edw. S. MacNabb Sons Inc. 301 Frederick Rd. Catonsville, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Rece. 3-22-72		25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons Inc.	

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

Feb. 1, 1901

FUNERAL DIRECTOR: IMPORTANT

THE MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 02845

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LONNIE DANEAL WILSON

2. DATE AND HOUR OF DEATH

3-19-72

7:17

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)THE JOHNS HOPKINS HOSPITAL
BALTIMORE, MD 212054. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

DELAWARE

NEW CASTLE

C. CITY OR TOWN

WILMINGTON

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

803 W. 10th STREET

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

03-18-72

9. AGE (In years
last birthday)If Under 1 Yr.
Months Days

3

If Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WILMINGTON, DELAWARE

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

JUNE WILSON

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

CAUSE OF DEATH

Intracerebral Hemorrhage

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 HOURS

(This does not mean the mode of dying, e.g.,
heart failure, pneumonia, etc., but the disease,
injury or complication which caused death)(A) IMMEDIATE CAUSE ~~PROBABLE NERVOUS SYSTEM~~
DUE TO, OR AS A CONSEQUENCE OF: HEMORRHAGECongenital Heart Disease
(B) ~~PROLONGED PROFOUND HYPOXIA~~ 2°
DUE TO, OR AS A CONSEQUENCE OF:

60 HOURS

(C) TO (TRANSPOSITION GREAT VESSELS) (CONGENITAL)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, EXAMINER giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

POSSIBLE PERICARDIAL EFFUSION

? 18 HOURS

19A. DATE OF OPERATION

3/17

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
CATH CYANOTIC HEART DISEASE

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/17/72 to 3/19/72
that (I) (we) last saw the deceased alive on 3/19/72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Peter R. Holbrook M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/19/72

23C. PHYSICIAN'S
NAME (Type)

PETER R. HOLBROOK

M.D. DEGREE

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

3/20/72

24C. NAME OF CEMETERY OR CREMATORY

Johns Hopkins Hospital

24D. LOCATION

City, town, or county

(State)

601 N Broadway, Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

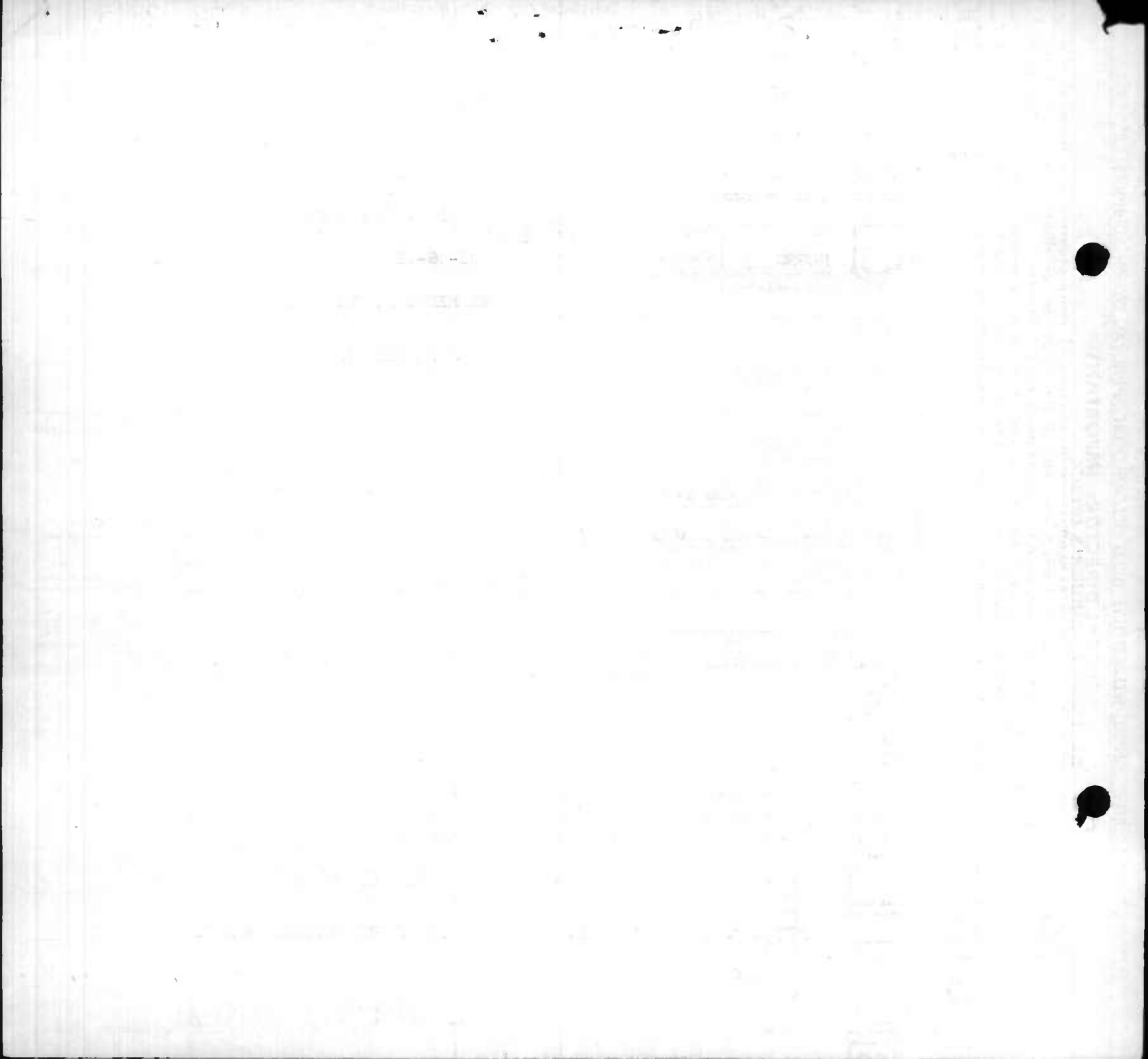
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 22 1972 RELEASED TO FUNERAL HOME

VS 150-REV. 1/71/68



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KIM DAVIS

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month Day Year

Hour

March 16, 1972

2:30 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location)

38 University Hospital

3. DATE
PRONOUNCED DEAD

Month Day Year

Hour

March 16, 1972

2:30 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1703

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

SEP 6, 1969

10. AGE (In years lost birthday)

2

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

706 Dolphin St.

11. BIRTHPLACE (State or foreign country)

BALTO, MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

VATES JACKSON

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

DENISE DAVIS

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

DENISE DAVIS 1931 A. COLLINGTON AVE

ADDRESS

19.

E188X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Blunt injuries of abdomen

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Respiratory infection

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

706 Dolphin Street

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

March 1972

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Charles S. Springate M.D.
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 16, 1972

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

3-72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 22 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

E. J. Brown, Jr.

ADDRESS

1703

5-31-1972 - Completion of cause of death on a pending medical examiner death certificate

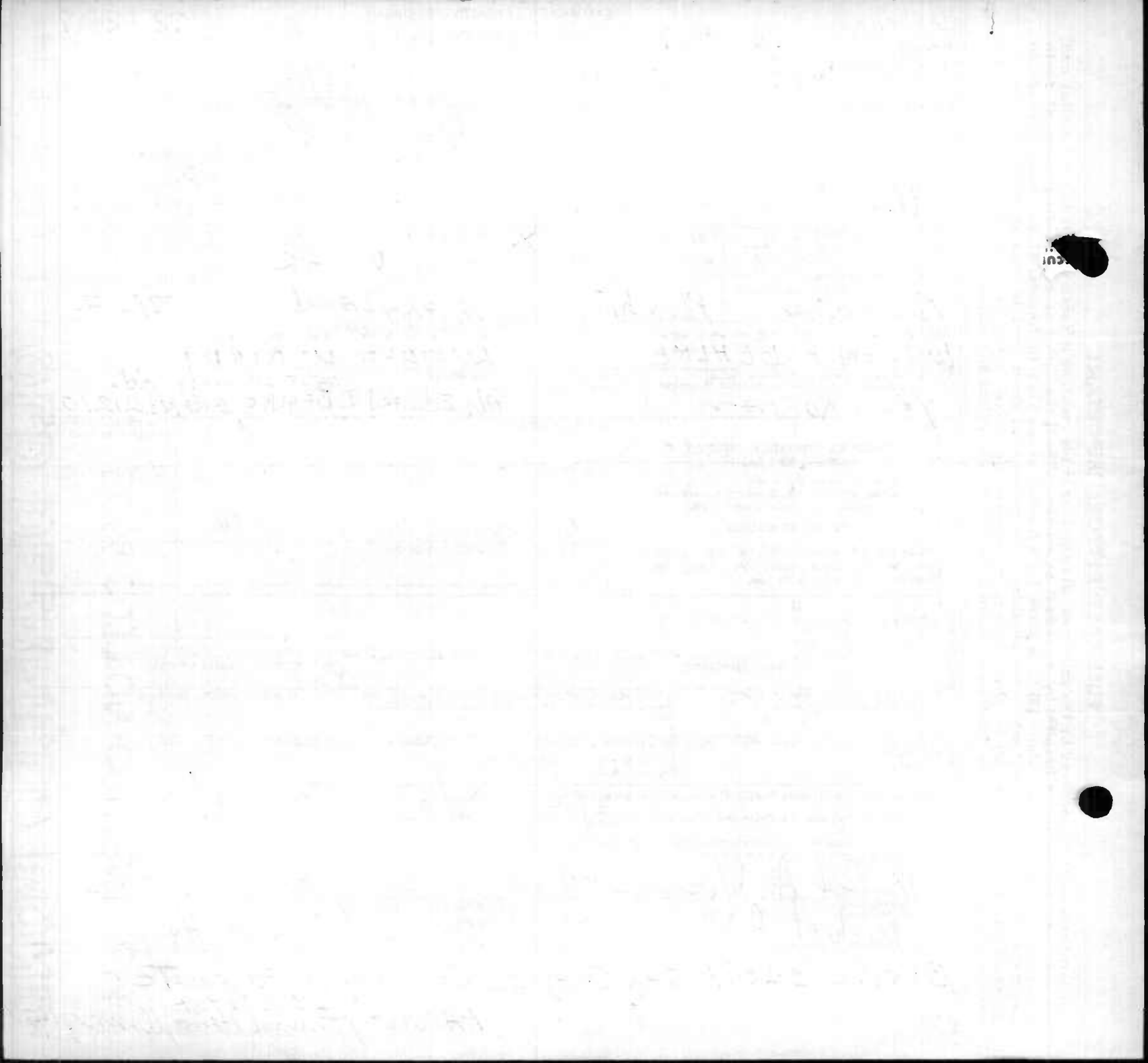
C. Springate, M.D.

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420		72 02847		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02847	
1. NAME OF DECEASED (Type or Print) <u>Floyd A. Behlke</u>				2. DATE AND HOUR OF DEATH <u>3/17/72</u> <u>11:15 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1101</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp</u>				C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1317 N. Calvert St. Balto. Md.</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/30</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM F. BEHLKE</u>				14. MOTHER'S MAIDEN NAME <u>LUCILLE D. Kirby</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>Mr. Edward J. Behlke</u> <u>4505 Winslow Rd. Balt. Md 21210</u>			
18. CAUSE OF DEATH <u>571.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>Encephalitis of the liver</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>Bronchopneumonia, left lower lobe</u> <u>(C)</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/15</u> 19 <u>72</u> to <u>3/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael A. Silverman MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/17/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Silverman MD</u>				23D. ADDRESS <u>Maryland General Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-20-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK CHAPEL Cem</u>		24D. LOCATION (City, town, or county) (State) <u>MAYOR Edgewater</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF REGISTRAR <u>266 E. E. H. 200</u>		25C. FUNERAL DIRECTOR <u>HARDESTY Funeral Home, Annapolis</u>			



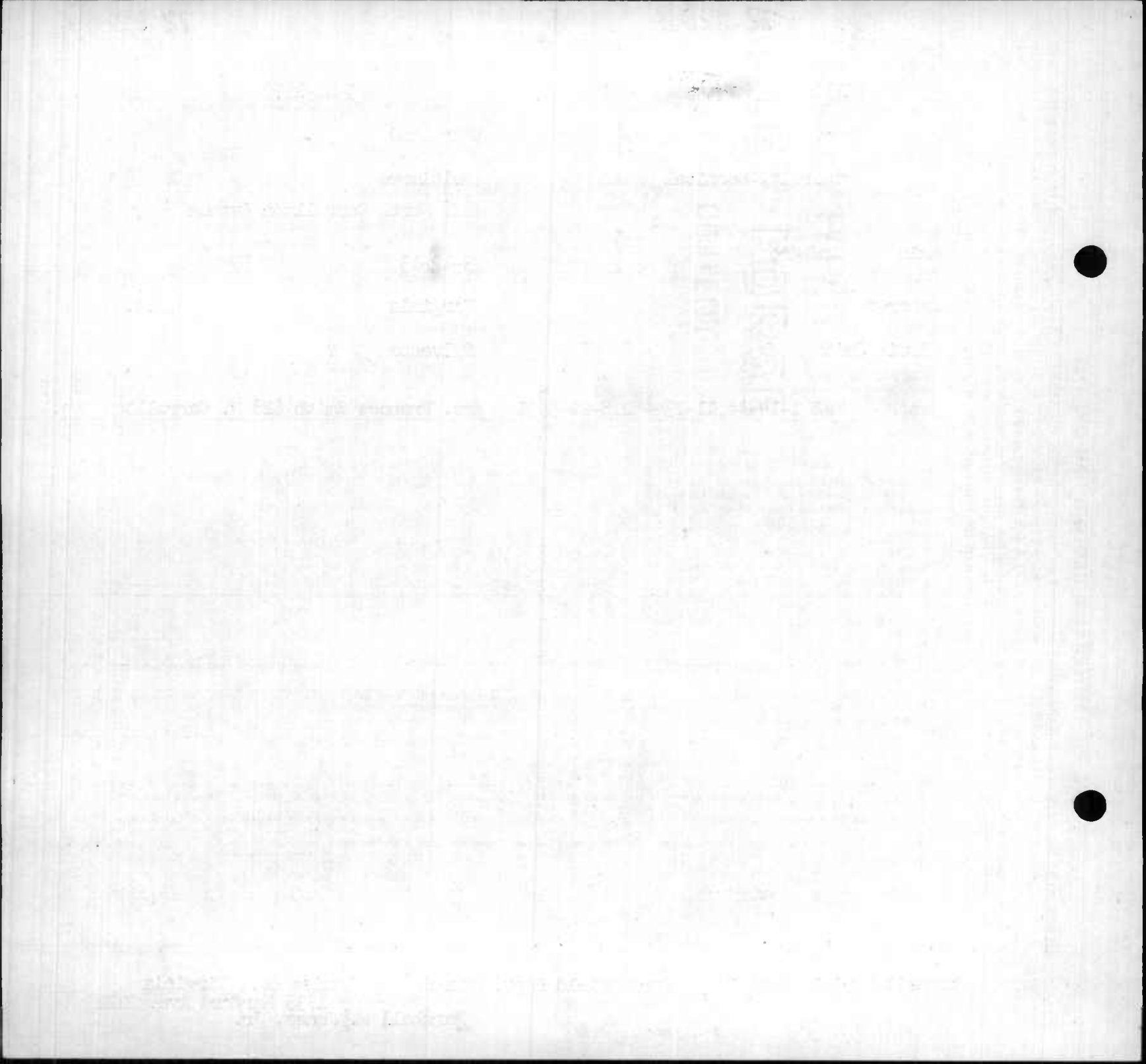
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-452		72 02848		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02848	
BIRTH NO.				72 02848			
1. NAME OF DECEASED (Type or Print) <u>OLENIA CZ - Mary</u>				2. DATE AND HOUR OF DEATH <u>3-21-72</u> <u>2:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>M.D. County Baltimore</u> B. COUNTY <u>604</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHEERCH, Home and Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>3-30-72</u>				CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>100 N Broadway</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-97</u>	9. AGE (In years last birthday) <u>74</u>	10. UNDER 1 Yr. Months Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>			11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Permanent</u>			13. FATHER'S NAME <u>Nelson</u>				
14. MOTHER'S MAIDEN NAME <u>—</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> If yes, give war or dates of service				
16. SOCIAL SECURITY NO. <u>4119 1406</u>			17. INFORMANT <u>Walter Olencz</u> ADDRESS <u>3718 Foster Ave</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4/23/25-09</u> S.S. 213-09-0505 <u>pulmonary edema</u>			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>CHF</u>						?	
(B) <u>ASHD and diabetes</u> DUE TO, OR AS A CONSEQUENCE OF:						?	
(C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-19-72</u> 19 <u>72</u> to <u>3-21-72</u> that (I) (we) last saw the deceased alive on <u>2 PM 3-21-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>DR- SAJADI</u> M.D. DEGREE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Typo) <u>DR- SAJADI</u> M.D. DEGREE				23D. ADDRESS <u>Church, Home and Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-24-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Michael's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF FUNERAL HOME		25C. FUNERAL DIRECTOR'S ADDRESS <u>Thelma R. Hoffman 3218 Hudson St</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530 72 02849		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02849	
1. NAME OF DECEASED (Type or Print) William James Smith				2. DATE AND HOUR OF DEATH 3-20-1972 2:00 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital 38				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 828 North Carrollton Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-13	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jimmie Smith				14. MOTHER'S MAIDEN NAME Sylvesta ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes #2 1-14-44, 11-23-45		16. SOCIAL SECURITY NO. 218-22-3931		17. INFORMANT ADDRESS Mrs. Frances Smith 828 N. Carrollton Ave. 21217			
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Septicemia Cardiac Arrest 10 yrs (C) none		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 18 1962 to March 20 1972, that (I) (we) last saw the deceased alive on Mar 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herbert L. Moseley, Jr.				23B. DATE SIGNED 3/20/72		23C. PHYSICIAN'S NAME (Type) Herbert L. Moseley, Jr., M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) transit-burial		24B. DATE 3-24-72		24C. NAME OF CEMETERY or CREMATORY Springfield Bapt. Church		24D. LOCATION (City, town, or county) (State) Louisa Co., Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert E. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213 Marshall W. Jones, Jr.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02850

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUDOLPH EPPS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 15 Year 1972 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1151 Whatcoat Street		3. DATE PRONOUNCED DEAD Month March Day 15 Year 1972 Hour 6:25 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6-15-35		10. AGE (in years last birthday) 36 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Winston Gester		14. MOTHER'S MAIDEN NAME Elizabeth Coleman	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 20A. DATE OF OPERATION 3-7-72		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 15, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) transit-burial		24B. DATE 3-19-72	
24C. NAME OF CEMETERY or CREMATORY Coleman Family Cemetery		24D. LOCATION (City, town, or county) (State) Crew, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert E. Jones, M.D.	
25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		25D. ADDRESS 35 Harford Avenue 21213	

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

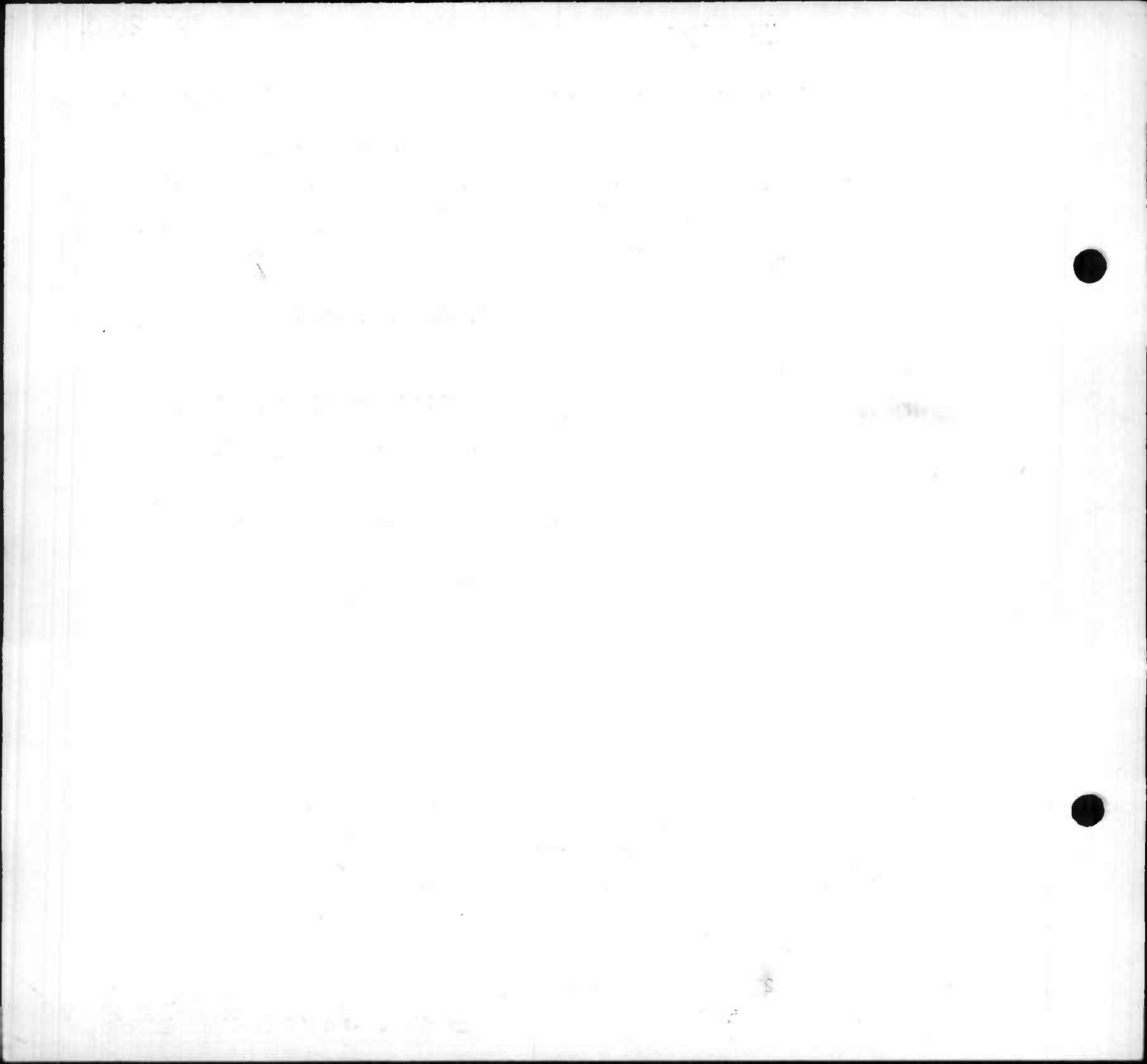
WATER RESOURCES DIVISION

WATER RESOURCES DIVISION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>R-240 72 02851 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02851</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) Ella Mae RUSSELL</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>2. DATE AND HOUR OF DEATH 3/19/72 3:03 A.M.</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital Loch Raven + Belvedere Ave</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Baltimore Md.</p>	
<p>5. SEX F 6. RACE B 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper</p>		<p>E. STREET AND NUMBER 3415 Edmondson Ave</p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>8. DATE OF BIRTH 4-10-20 9. AGE (In years last birthday) 51</p>	
<p>11. BIRTHPLACE (State or foreign country) Pineville, N. Carolina</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Jenkins Robert</p>		<p>14. MOTHER'S MAIDEN NAME Thompson, Mary</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 241-38-2600</p>	
<p>17. INFORMANT Mr. Elijah Russell, Sr.</p>		<p>ADDRESS 3415 Edmondson Ave. 21229</p>	
<p>18. CAUSE OF DEATH 01701</p>		<p>POSSIBLE TAMPONADE</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: LUPUS PERICARDITIS</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: LUPUS</p> <p>(C)</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) Yes</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location) Just - no</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR?</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> 19 <u>72</u> to <u>3/19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE E. Feinglass MD</p>		<p>23B. DATE SIGNED 3/19</p>	
<p>23C. PHYSICIAN'S NAME (Type) E. FEINGLASS</p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) burial</p>		<p>24B. DATE 3-23-1972</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, MD</p>	
<p>25C. FUNERAL DIRECTOR Purnell B. Oden</p>		<p>ADDRESS 1735 Harford Ave. 21213 Jones Funeral Homes</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02852
BIRTH NO. R-521		72 02852 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) CLARA J. REINSFELDER		2. DATE AND HOUR OF DEATH 3/21/72 12:30 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GEN. HOSP. 48		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 102 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 503 S. Robinson St.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/17	9. AGE (In years lost birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas WITKA		14. MOTHER'S MAIDEN NAME Elizabeth Kowalski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-5105		17. INFORMANT Frank S. Reinsfelder Medical Record
18. I 154,11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) CARCINOMA OF RECTUM C METASTASES DUE TO, OR AS A CONSEQUENCE OF: (C) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION				
19A. DATE OF OPERATION 1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Rectum		
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>2-6-72</u> 19<u>72</u> to <u>3-21-72</u> 19<u>72</u> that (I) (we) last saw the deceased alive on <u>3-21-72</u> 19<u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE C. C. Usgo MD				23B. DATE SIGNED 3/21/72
23C. PHYSICIAN'S NAME (Type) C. C. Usgo MD				23D. ADDRESS MARYLAND GEN HOSP.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-1972		
24C. NAME of CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robt E. Kelly, Jr.		
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.		

The first of the season was a very fine day, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The second day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The third day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The fourth day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The fifth day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The sixth day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The seventh day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The eighth day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

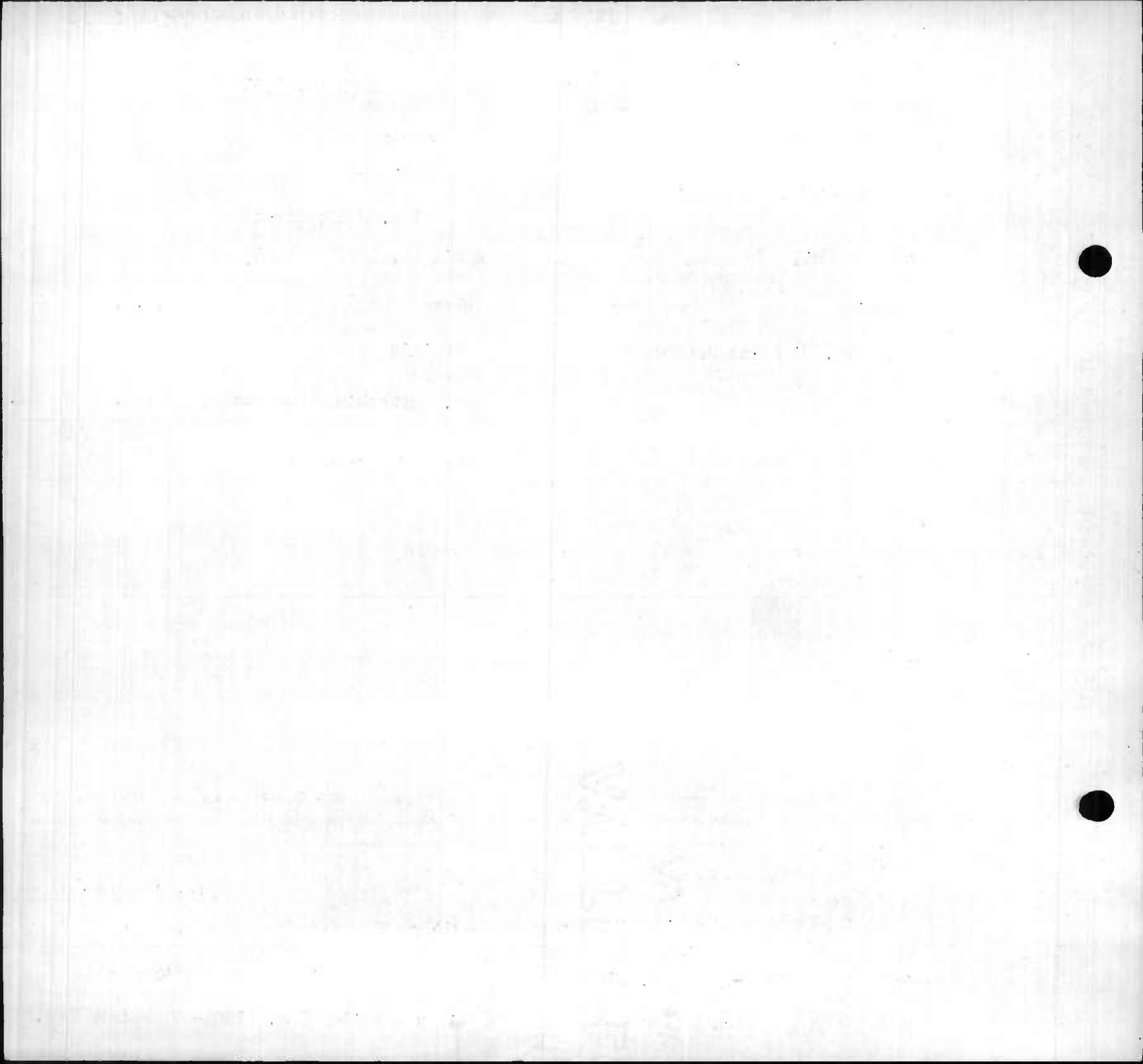
The ninth day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

The tenth day was also very fine, the sun shone
 brightly and the air was cool and refreshing. We went for a
 walk in the park and saw many beautiful flowers in bloom.
 The children were very happy and played for hours. We
 also saw many beautiful birds and insects. The day was
 very pleasant and we all enjoyed it very much.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

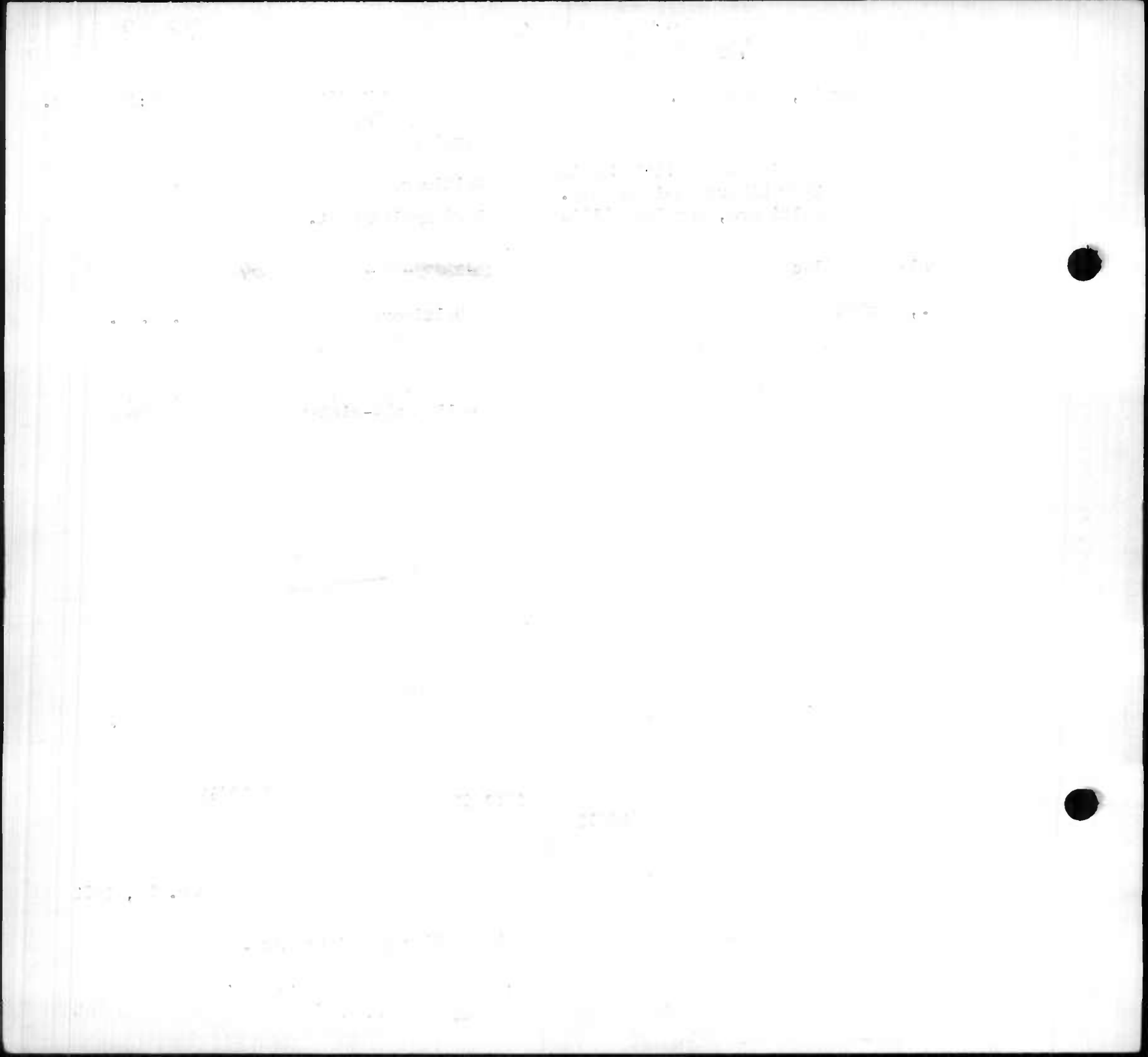
BALTIMORE CITY HEALTH DEPARTMENT				72 02853	REG. NO.
W-242 BIRTH NO. 72 02853 1. NAME OF DECEASED (Type or Print) DARIA WESOLOWSKYJ		CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital		2. DATE AND HOUR OF DEATH March 20, 1972 M.			
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 203	
13. FATHER'S NAME Rev. Nicholas Butkowsky		14. MOTHER'S MAIDEN NAME Eugenia		9. AGE (In years last birthday) 73 11. BIRTHPLACE (State or foreign country) Ukrain 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rev. Eustachius Wesolowskyj 511 S. Wolfe St.	
18. 410.9 I					
CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute coronary occlusion					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.H.S.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 to March 20 1972, that (I) (we) last saw the deceased alive on March 20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 3/22/72	
23C. PHYSICIAN'S NAME (Type) ANDREW LEMISCHKA MD				23D. ADDRESS 2608 E. BALTIMORE ST BALTO 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-1972		24C. NAME OF CEMETERY OR CREMATORY St. Michael	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR John E. Galt, M.D.		25C. FUNERAL DIRECTOR Billy & Zeiler Inc.	
ADDRESS 1901-07 Eastern Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-620		72 02854		72 02854	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Harris, Norman R.			3/20/72 9:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215			A. STATE Maryland B. COUNTY 1502		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			1654 Appleton St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Male	Black	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-10-14	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
B.B. Market			Baltimore		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Alfred Harris			Rosella Queen		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			218186075		
17. INFORMANT			ADDRESS		
Orlando Armanella Banks			Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			3 days		
ANTECEDENT CAUSES			Years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II			Bacterial Endocarditis Pneumonia 5 weeks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/21/72 19 to 3/20/72 19 that (I) (we) last saw the deceased alive on 3/20/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
M. J. S. H. A. F. I.			Mar. 20, 1972		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
S. H. A. F. I.			2600 Liberty Heights Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3-24-72		Arbutus Mem. Pk/	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 22 1972		B. J. S. H. A. F. I.		V. Bailey	
25D. LOCATION (City, town, or county)		25E. ADDRESS			
Balto., Md.		1348 Calhoun Street			



B-400

72 02855 BALTIMORE CITY HEALTH DEPARTMENT

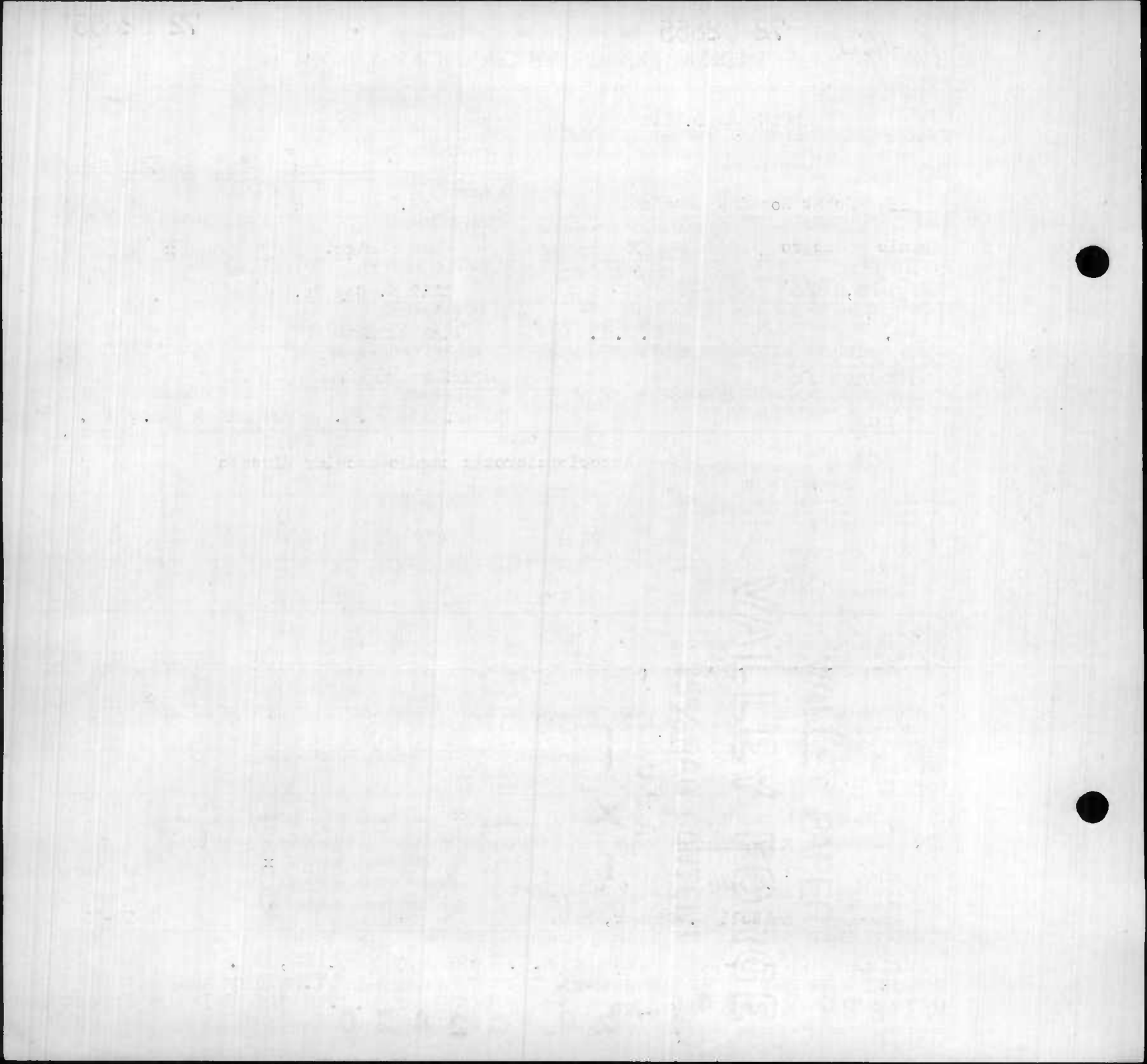
72 02855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ADDIE LEE BAILEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 19 1972 9:16 a M.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 808	
9. DATE OF BIRTH May 16, 1828		10. AGE (in years lost birthday) 43 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Nollie Collins		13. FATHER'S NAME John Townsend	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT CC Humble F.H.		ADDRESS Accomack Co., Va.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-20-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-30-72	
24C. NAME of CEMETERY or CREMATORY Burton M.C. Cemetery		24D. LOCATION (City, town, or county) (State) Melfa, Va.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun Street	



A-620

72 02856

BALTIMORE CITY HEALTH DEPARTMENT

72 02856

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Robert F. Harris				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 21 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 733 Mt. Holly St.				3. DATE PRONOUNCED DEAD Month 3 Day 21 Year 72 Hour 8:30 a. M.	
6. SEX male				7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1608	
9. DATE OF BIRTH 6-16-02				10. AGE (In years last birthday) 69	
11. BIRTHPLACE (State or foreign country) VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				15. MOTHER'S MAIDEN NAME —	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				17. SOCIAL SECURITY NO.	
18. INFORMANT MARY HARRIS				ADDRESS same	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 3/21/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-72		24C. NAME OF CEMETERY or CREMATORY Arbatus Mem. Pk.	
24D. LOCATION (City, town, or county) Balto.		24E. STATE (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972		25B. NAME OF REGISTRAR Robert F. Harris		25C. FUNERAL DIRECTOR V.R. Bailey ADDRESS 1348 N. Calhoun St.	

AGRICULTURAL JOURNAL

AGRICULTURE

VALLEY FARMERS CO

1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

T-653 72 02857

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02857

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER TRENT				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 3 20 1972 9:15 a M			
6. SEX male				7. RACE negro		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Feb 28, 1924				10. AGE (In years last birthday) 48		C. CITY OR TOWN Balto.	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.				12. CITIZEN OF WHAT COUNTRY? U. S. A.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY ABERDEEN PROVING GR.		15. MOTHER'S MAIDEN NAME Daisey Mae Trent	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1943-1946				17. SOCIAL SECURITY NO. 207-12-4463		18. INFORMANT Mrs. Audrey Trent	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 3-23-72				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-20-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3-23-72		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Pk.	
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972				25B. NAME OF REGISTRAR <i>John E. Fisher</i>		25C. FUNERAL DIRECTOR Morton & Dyett F. H.	
24D. LOCATION (City, town, or county) Baltimore, Maryland				24E. ADDRESS 1701 Laurens St.			

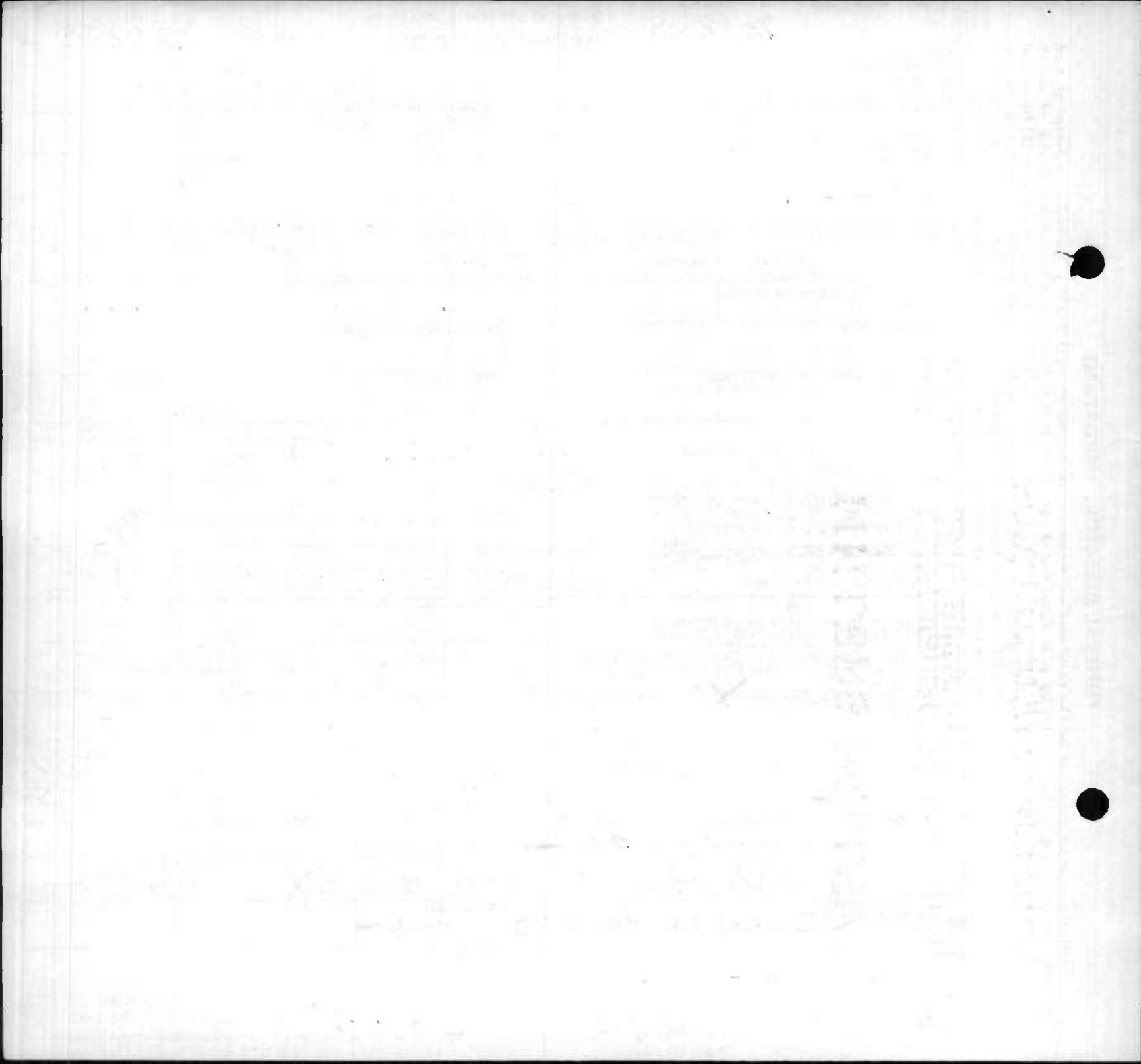
4-5-1972 - Completion of cause of death on a pending medical examiner death certificate.
Russell S. Fisher, M.D.

HRS

FUNERAL DIRECTOR: IMPORTANT

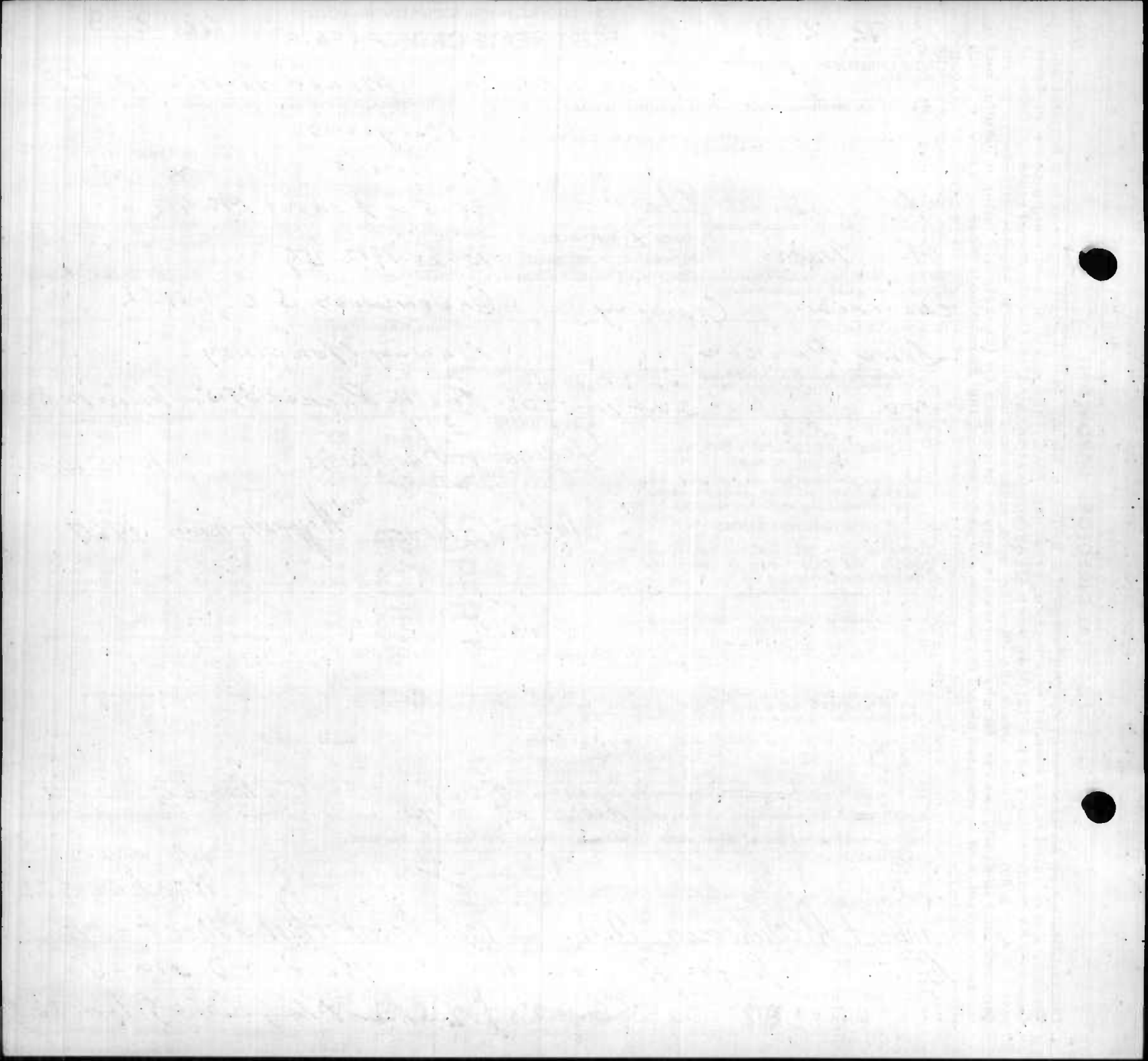
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		72 02858		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02858	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <u>ARTHUR JONES</u>				2. DATE AND HOUR OF DEATH <u>3/21/72</u> <u>12:55</u> a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MGH - Md. General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-01</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1820 Bolton St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-12</u>	9. AGE (in years last birthday) <u>60</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Jones</u> ADDRESS <u>same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cranio cerebral Injuries</u> <u>resp. failure</u> (This does not mean the mode of dying, e.g., heart failure, etc., but the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASE OR CONDITION EXISTING PRIOR TO THE ABOVE CAUSE (A) stating the UNDERLYING CONDITION last. <u>Head trauma -> subdural</u> <u>hematoma</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Brain (CNS) damage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Head trauma -> subdural</u> <u>hematoma</u> (C) <u>hematoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>3/5/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Head Trauma</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1820 Bolton St/1401</u>			
21D. TIME OF INJURY (APPROX.) <u>3/4/72 4:15 pm</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell while intoxicated</u>			
22. I certify that (this hospital) attended the deceased from <u>3/4</u> 19 <u>72</u> to <u>3/21</u> 19 <u>72</u> that (we) last saw the deceased alive on <u>3/20</u> 19 <u>72</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <u>Juan M. Pardo MD</u>				23B. DATE SIGNED <u>3/21/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>JUAN M. PARDO MD</u>				23D. ADDRESS <u>MGH</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-25-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF REGISTRAR <u>Reed 3027</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>1348 Calhoun Street</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02859		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02859	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>PAUL PARKER SR.</i>		2. DATE AND HOUR OF DEATH <i>MARCH 18-1972 10.45P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1509</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hosp.</i>		E. STREET AND NUMBER <i>3415 W. FURST PK. 97</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-1912 59</i>	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHAUFFEUR</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Germany</i>		11. BIRTHPLACE (State or foreign country) <i>Greenwood S.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Parker</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Monahan</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>248-10-5506</i>		17. INFORMANT <i>Fun. R. Parker 3515 W. Furst PK. 97</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arterio sclerosis And Hypertension</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-15 mins.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Obesity</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-8-67</i> 19 <i>72</i> to <i>March 17</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>March 17</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Albert R. Wilkerson M.D.</i>		23B. DATE SIGNED <i>March 20, 1972</i>		23C. PHYSICIAN'S NAME (Type) <i>Albert R. Wilkerson, M.D.</i>	
23D. ADDRESS <i>1200 Saint Paul Street - 21202</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>3/22/72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Arboretum Mon PK</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore 21227</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAR 22 1972</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Wm. H. ...</i>		25D. ADDRESS <i>6386 S. ...</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02860

BIRTH NO. 72 02860

1. NAME OF DECEASED
(Type or Print)

Mc Cant James

2. DATE AND HOUR OF DEATH

March 21, 72 1 05 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39

Provident Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

md

1513

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2600 Loyola South way

5. SEX

m

6. RACE

N

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-26-15

9. AGE in years

56 yr

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER CON CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgetown S.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

CAIN McCANT

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

250-48-5532

17. INFORMANT

ADDRESS

F/3085TN McCANT 2600 Loyola S way

18. 412.41

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Acute atherosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

CHHF, anhydrosis

DUE TO, OR AS A CONSEQUENCE OF:

Chronic obstructive pulmonary emphysema

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Pneumonitis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

1 Month (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 20 19 72 to March 21 19 72 that (I) (we) last saw the deceased alive on March 21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

V. Chitaplee

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

3-21-72

23C. PHYSICIAN'S NAME (Type)

V. Chitaplee

23D. ADDRESS

Provident Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 3/24/72

Mt Auburn

BALTIMORE

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

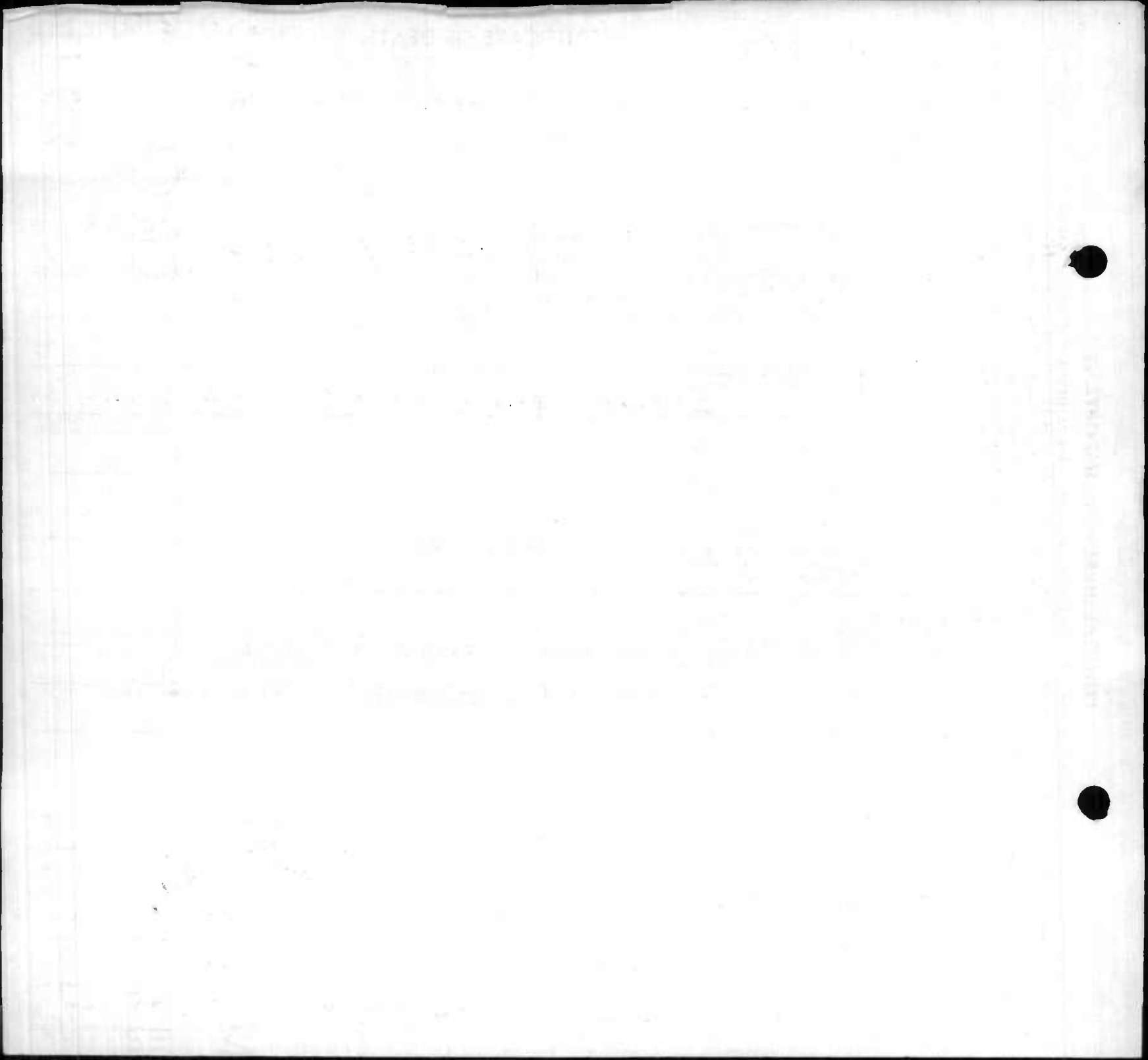
25C. FUNERAL DIRECTOR

ADDRESS

MAR 22 1972

Robert E. Fisher, R.D.

Miss Mary 638 n 90/nn 88



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 02861

BIRTH NO. 72 02861

1. NAME OF DECEASED
(Type or Print)

Parker, Orabelle

2. DATE AND HOUR OF DEATH

3/20/72

12:30

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital Complex
2600 Liberty Heights Ave.
Baltimore, Maryland 21215

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4507 Norfolk Ave.

5. SEX

Female

6. RACE

Black

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

01/10/05

9. AGE (in years last birthday)

67

10. UNDER 1 Yr. Months: Days

11. UNDER 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va. 9/6/05/08/09

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Washington

14. MOTHER'S MAIDEN NAME

IN 53 Curtis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Romeo McClarry-Daughter

ADDRESS

Same

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/20/72 19 to 3/20/72 19 that (I) (we) last saw the deceased alive on 3/20/72 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23B. DATE SIGNED

March 20, 1972

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

2600 Liberty Heights Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 22 1972

Robert E. Taylor

Mr. J. S. G. Hays 638 1/2 9th St

107 North Ave.

James McGlarry-James McGlarry

107 North Ave.

107 North Ave.

107 North Ave.

107 North Ave.

G-650

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>David W. (Junior) Green</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>3</u> Day <u>11</u> Year <u>72</u> Hour <u></u> M. <u></u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>3301 Woodland Avenue</u>		3. DATE PRONOUNCED DEAD Month <u>3</u> Day <u>11</u> Year <u>72</u> 3:30 p. M.	
6. SEX <u>male</u>		7. RACE <u>Negro</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>	
9. DATE OF BIRTH <u>Aug 15, 1922</u>		10. AGE (In years lost birthday) <u>49</u>	
11. BIRTH PLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <u>Johnie Mack Green</u>		ADDRESS <u>1308 Poplar Grove St</u>	
19. <u>E 8721 X</u>		CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE <u>Carbon monoxide poisoning</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>between 3/9/72 and 3/11/72-Time: Unknown</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>3301 Woodland Avenue</u>		22F. HOW DID INJURY OCCUR? <u>Subject inhaled carbon monoxide poisoning</u>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Not of natural cause</u> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <u>yes</u>	
ACTUAL SIGNATURE <u>Peter Lipkovic</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>3/24/72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Chapel Cer</u>		24D. LOCATION (City, town, or county) (State) <u>KING STREET SC.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. [illegible]</u>	
25C. FUNERAL DIRECTOR <u>Joseph & [illegible]</u>		ADDRESS <u>2222 W. [illegible] Ave</u>	

4-28-1972 - Letter - Office of the Chief Medical Examiner, Peter Lipkovic, M.D. .
Assistant Medical Examiner

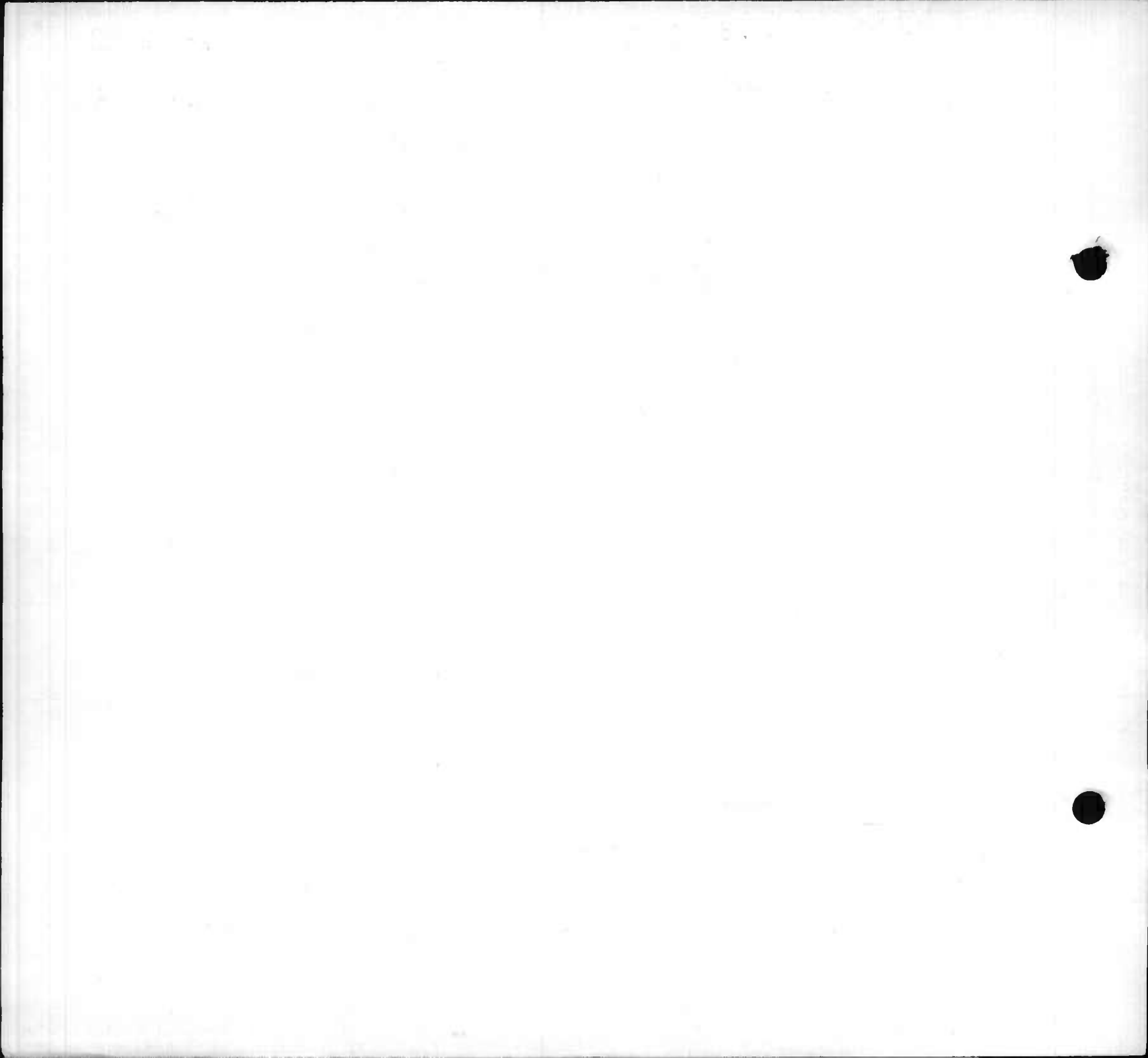
HRS.

6/2/72- Carbon-monoxide from space heater

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

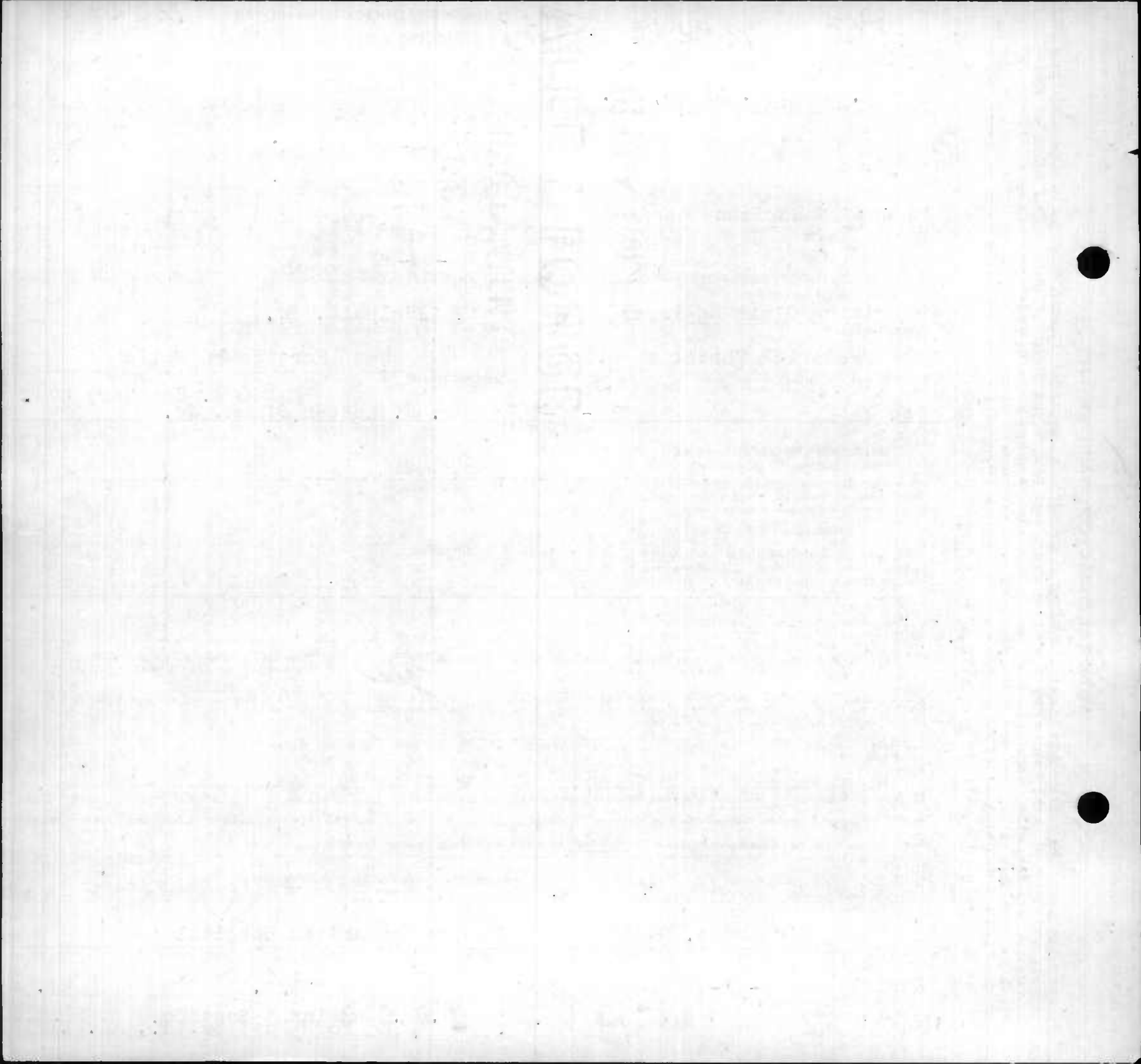
D-620 72 02863		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02863	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Samuel Dorsey</i>		2. DATE AND HOUR OF DEATH <i>15 MARCH 1972 6:40 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>4838 Pimlico Rd.</i>		A. STATE <i>MARYLAND</i>		B. COUNTY <i>2717</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4838 Pimlico Road</i>					
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/18/09</i>	9. AGE (In years last birthday) <i>62</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>John Dorsey</i>			
14. MOTHER'S MAIDEN NAME <i>Maggie Hall</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 6 Jan 43 20 Oct 45</i>			
16. SOCIAL SECURITY NO. <i>442-09-9647</i>		17. INFORMANT <i>Francis Bohron</i>			
ADDRESS <i>4838 Pimlico Rd.</i>					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hepatoma</i>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2 March</i> 19 <i>72</i> to <i>15 March</i> 19 <i>72</i> that (I) (we) lost saw the deceased alive on <i>14 March</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Morris Ostroff</i>		23B. DATE SIGNED <i>3/15/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Morris Ostroff</i>	
23D. ADDRESS <i>Smor Hospital of Balt.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-18-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Maryland National Cemetery</i>	
24D. LOCATION <i>Maryland</i>		24E. (City, town, or county) (State) <i>Ind.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 22 1972</i>		25B. NAME OF REGISTRAR <i>Robert J. B...</i>		25C. FUNERAL DIRECTOR <i>Joseph L. B...</i>	
ADDRESS <i>2222 W. North Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

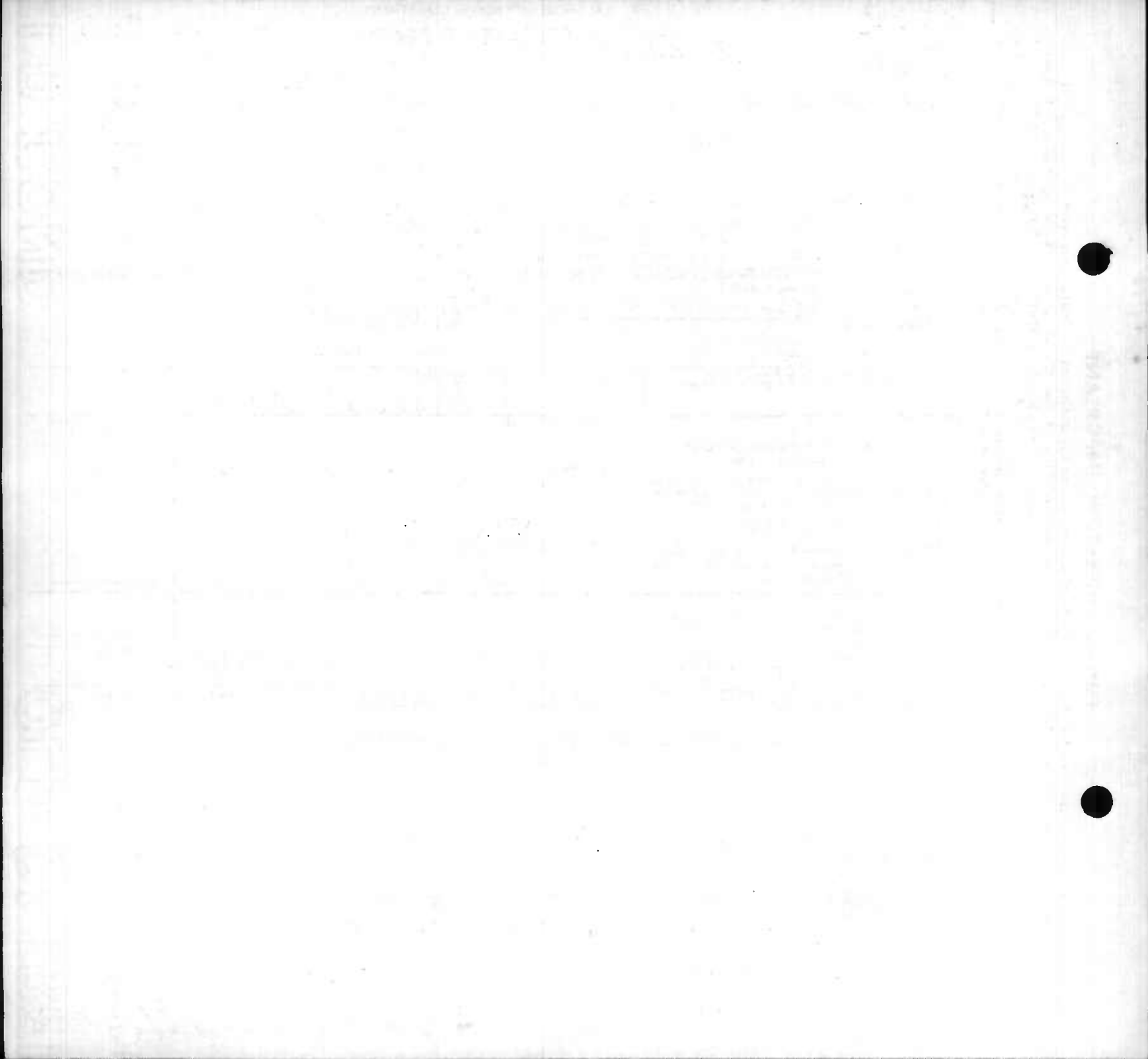
BALTIMORE CITY HEALTH DEPARTMENT		72 02864		72 02864	
BIRTH NO.		REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
F. Lester Simon, Sr.		3/19/72		11:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 45 The Good Samaritan Hospital		A. STATE		B. COUNTY	
		Maryland			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Baltimore 21210		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		F. INSIDE CITY LIMITS?			
15 Englewood Road 21210		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Male	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	09-04-89	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Consulting Civil Engineer		Philadelphia, Pa.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Frederick Christian Simon		Mary Bowen Potts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-10-7596		806 E. Seminary Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 mo	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/28 1972 to 3/19 1972, that (I) (we) last saw the deceased alive on 3/19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Richard J. Owellen MD		5/19/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Richard J. Owellen		Good Samaritan Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		3-22-72		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAR 22 1972		J. H. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was, in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 72 02865	
K-400 72 02865 CERTIFICATE OF DEATH											
BIRTH NO.				1. NAME OF DECEASED (Type or Print) KELLY, Paul				2. DATE AND HOUR OF DEATH 3/20/72 9:40 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 808							
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1219 N. Caroline Street											
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/26/20		9. AGE (In years last birthday) 51		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Selma N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Kelly				14. MOTHER'S MAIDEN NAME Annie McGullum							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 291.01 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Delirium Tremens. (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3/18 1972 to 3/20 1972 that (I) (we) last saw the deceased alive on 3/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Robert D. Kramer MD				23B. DATE SIGNED 3/20/72							
23C. PHYSICIAN'S NAME (Type) Robert D. Kramer, MD				23D. ADDRESS The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 3/23/72		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Selma N.C.					
25A. DATE REC'D BY HEALTH DEPT. MAR 22 1972				25B. NAME OF REGISTRAR Robert D. Kramer				25C. FUNERAL DIRECTOR R. Sanders 317 E. Preston St			

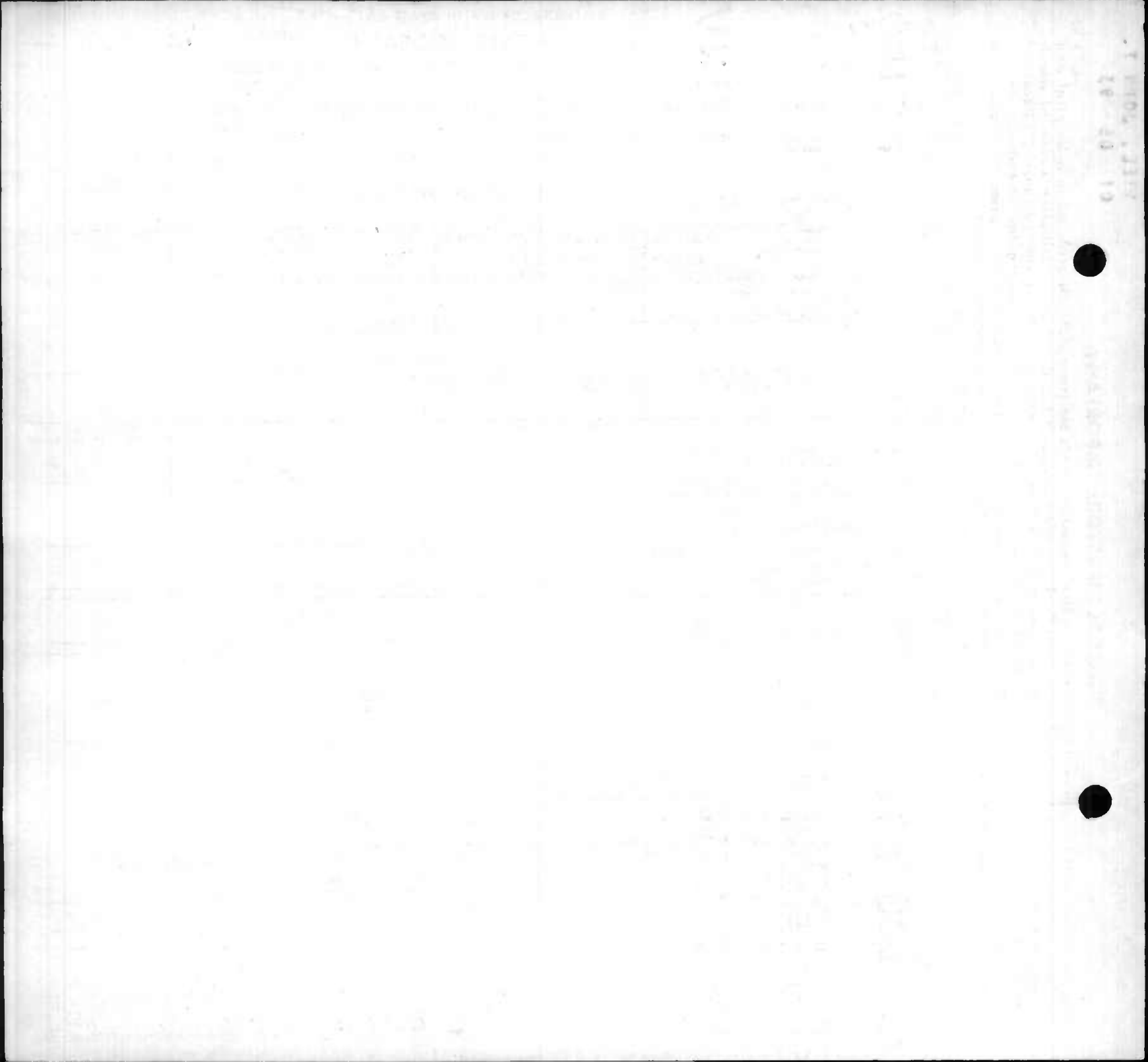


VIEL, JOHN T.
01 03 93

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>V-400</u>					REG. NO. <u>72 02866</u>				
1. NAME OF DECEASED (Type or Print) <u>VIEL, John</u>					2. DATE AND HOUR OF DEATH <u>3/20/72</u> <u>12:24 a.m.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 271, Rt. 15 Chesapeake Avenue</u>				
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/93</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Conrad Viel</u>			14. MOTHER'S MAIDEN NAME <u>Wilhelmina Kraus</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife</u> ADDRESS <u>Same</u>				
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>pneumonia, sepsis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>stroke, m-i, UTI</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
19A. DATE OF OPERATION <u>—</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <u>NO</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>March 1</u> 19 <u>72</u> to <u>March 20</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>March 20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Penelope P. Scott M.D.</u>					23B. DATE SIGNED <u>3/20/72</u>		23C. PHYSICIAN'S NAME (Type) <u>PENELOPE SCOTT M.D.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3/23/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Immanuel Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>			25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>P. ...</u>		ADDRESS <u>6067 Taft Rd</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-400		72 02867		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02867	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Sweeley, Lynn A</u>				2. DATE AND HOUR OF DEATH <u>3-18-72 16:35 P M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>						C. CITY OR TOWN <u>ESSEX</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>3227 George St. Baltimore, Md. 21220</u>						005			
5. SEX <u>Male</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-11</u>		9. AGE (In years last birthday) <u>60</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY <u>WESTING HOUSE</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Harry</u>			
14. MOTHER'S MAIDEN NAME <u>Helen LYNN</u>						15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>UNK</u> If yes, give war or dates of service			
16. SOCIAL SECURITY NO. <u>205-03-1399</u>						17. INFORMANT <u>BCH Records: 4940 Eastern Ave. Baltimore, Md. 21224</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Polyarteritis nodosa</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>6 months</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>3-6-1972</u> to <u>3-18-1972</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Chu-shin chin MD</u>						23B. DATE SIGNED <u>3-18-72</u>		23C. PHYSICIAN'S NAME (Type) <u>CHU-SHIN CHIU MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>						24B. DATE <u>3/21/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>	
24D. LOCATION (City, town, or county) <u>BALTO. MD.</u>						24E. LOCATION (State) <u>BALTO. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 22 1972</u>						25B. NAME OF REGISTRAR <u>John E. Kelly, MD.</u>		25C. FUNERAL DIRECTOR <u>JOE CONNELLY</u>	
25D. ADDRESS <u>300 MACE</u>									

13 18 72

143

60-43-29

SWEETLEY, LYNN

3227 GEORGE ST.

BALTO, MD. 21220 005

10-18-11 WM-P 4 Gt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-352 72 02868</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02868</p>	
<p>1. NAME OF DECEASED (Type or Print) <i>Mrs. Florence V. Stansbury</i></p>		<p>2. DATE AND HOUR OF DEATH <i>3/19/72 7:21 P.M.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>48 Maryland General Hospital</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Harford</i></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland General Hospital</i></p>		<p>C. CITY OR TOWN <i>Harford</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
		<p>E. STREET AND NUMBER <i>209 N. Stokes Street</i></p>	
<p>5. SEX <i>Female</i></p>	<p>6. RACE <i>negro</i></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>May 12, 1887</i></p>
<p>9. AGE (in years last birthday) <i>85</i></p>		<p>10. UNDER 1 Yr. Months: <i>0</i> Days: <i>0</i></p>	<p>11. UNDER 24 Hrs. Hours: <i>0</i> Min: <i>0</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife (Ret.)</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <i>Private Family</i></p>	
<p>11. BIRTHPLACE (State or foreign country) <i>Harford County Md.</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>Henry L. Christy</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Isabella Jenson</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>217-26-7666A</i></p>	
<p>17. INFORMANT <i>Mrs. Helen J. Cook</i></p>		<p>ADDRESS <i>209 N. Stokes St. Harford Md. 21078</i></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial infarction</i></p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Embolization of R. vent. & infarction of myocardium</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pulmonary emboli</i></p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION <i>3/15/72</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sinus arrest</i></p>	
<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <i>3/3</i> 19 <i>72</i> to <i>3/19</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>3/19</i> 19 <i>72</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Louis E. Bremer</i></p>		<p>23B. DATE SIGNED <i>3/19/72</i></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>3-24-72</i></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery Inc.</i></p>		<p>24D. LOCATION (City, town, or county) (State) <i>Harford, Md.</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1972</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert E. Baker, M.D.</i></p>	
<p>25C. FUNERAL DIRECTOR <i>John J. Bullock</i></p>		<p>ADDRESS <i>556 Lenoir St. Harford Md. 21078</i></p>	

1891

1892

1893

1894

1895

1896

1897

1898

1899

1900

1901

1902

1903

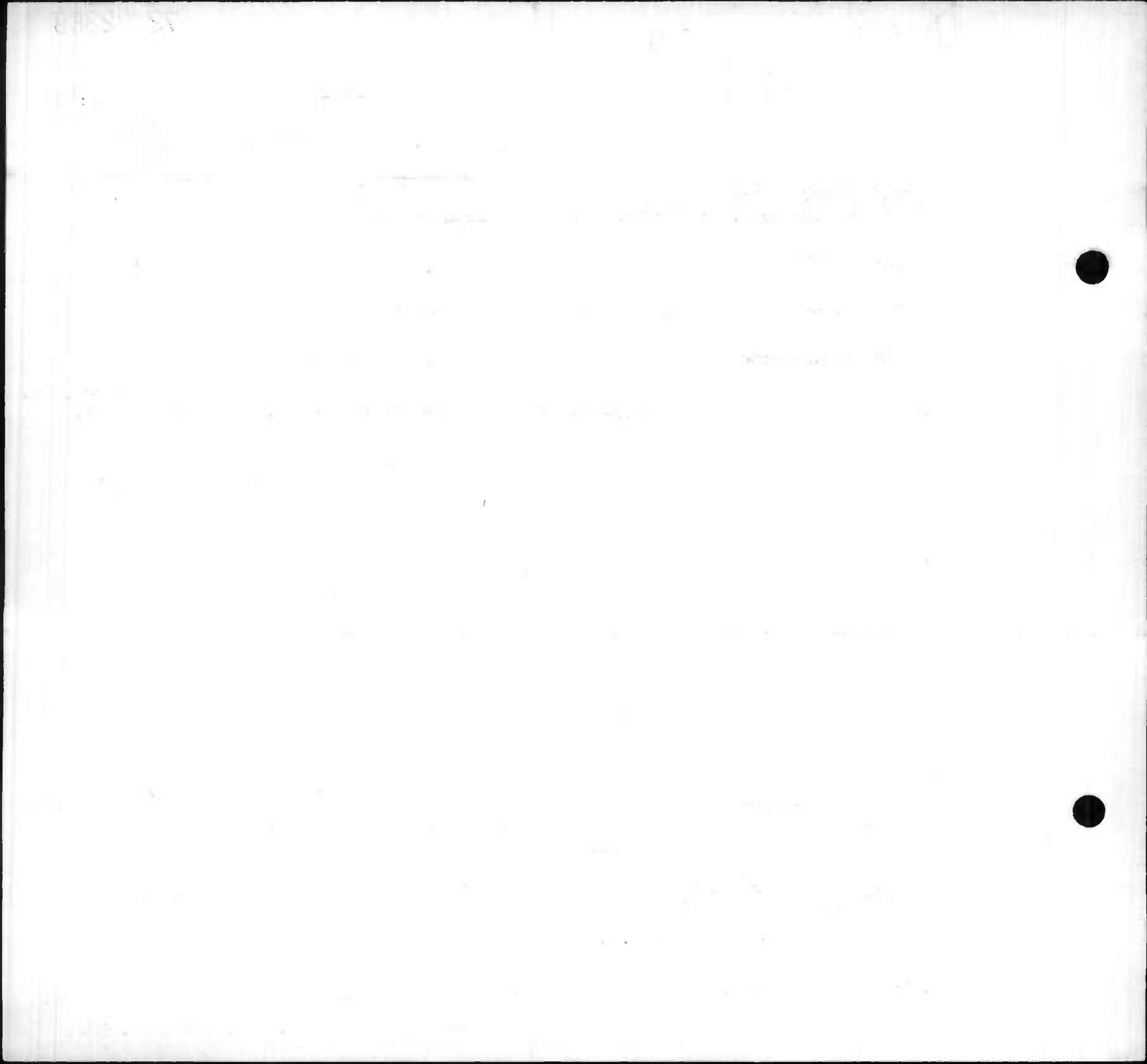
1904

1905

1906

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

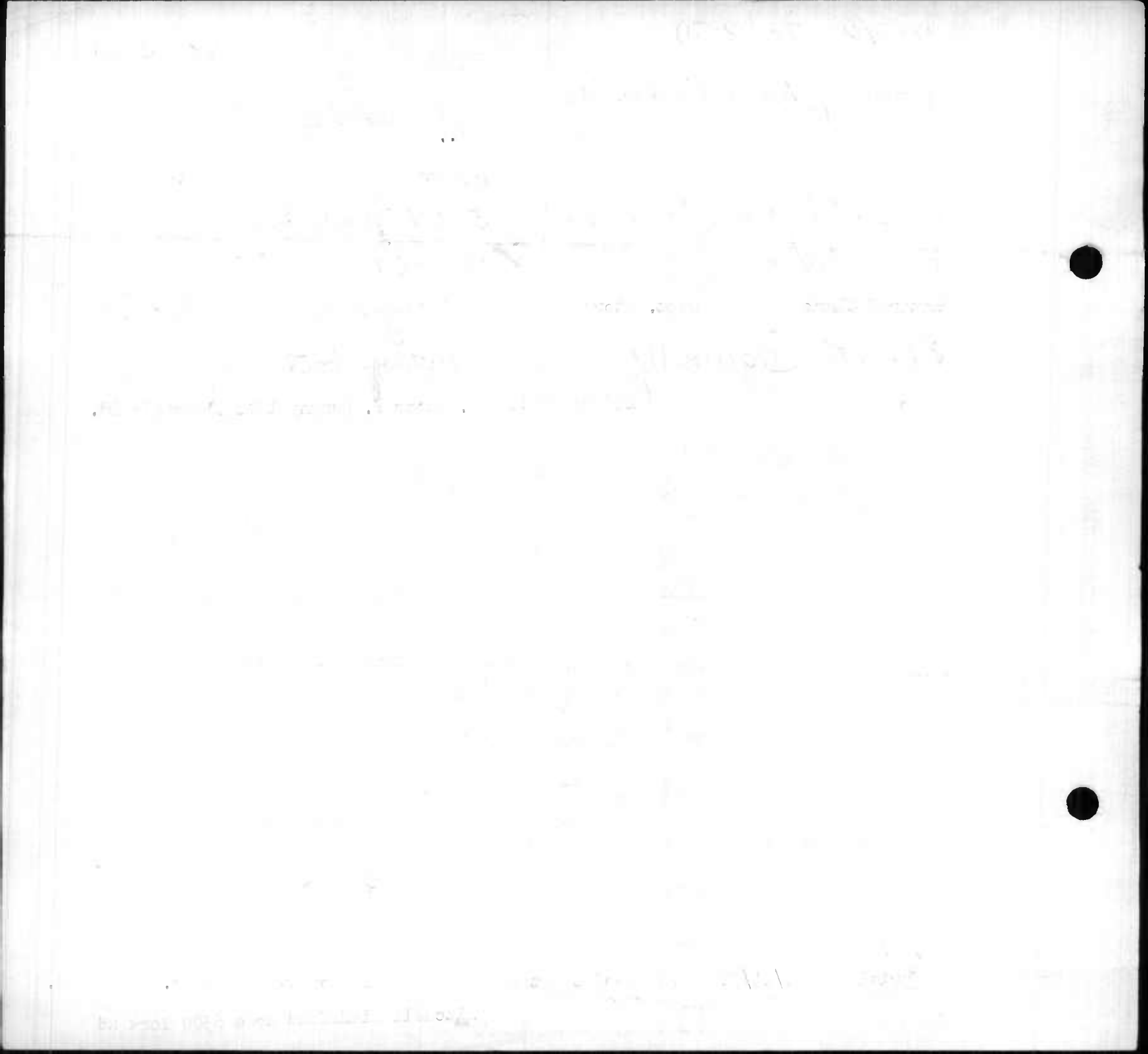
D-120		72 02869		BALTIMORE CITY HEALTH DEPARTMENT		72 02869	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Julia Anna/Davis				2. DATE AND HOUR OF DEATH 3-21-72 8:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Nursing Home 6116 Bel Air Road, Baltimore, Md.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Harford 6200			
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH Feb. 18, 1891		9. AGE (in years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boarding House Opr.				10B. KIND OF BUSINESS OR INDUSTRY Boarding House		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James D. Metts				14. MOTHER'S MAIDEN NAME Sophia V. Carter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 217-36-3106		17. INFORMANT Charles Raymond Davis, 2030 Cherry Road, Edgewood, Md.	
18. 486X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Bronchitis				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Arteriosclerosis, Chronic Brain Syndrome							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/9/1970 to 3/21/1972 that (I) (we) last saw the deceased alive on 3/20/1972 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 3/21/72			
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.				23D. ADDRESS 4900 Belair Road 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 24, 1972		24C. NAME OF CEMETERY or CREMATORY Trinity Lutheran Cemetery		24D. LOCATION (City, town, or county) (State) Joppa Harford Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR Howard K. McComas, III		25C. FUNERAL DIRECTOR'S ADDRESS Howard K. McComas, III, Abingdon, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

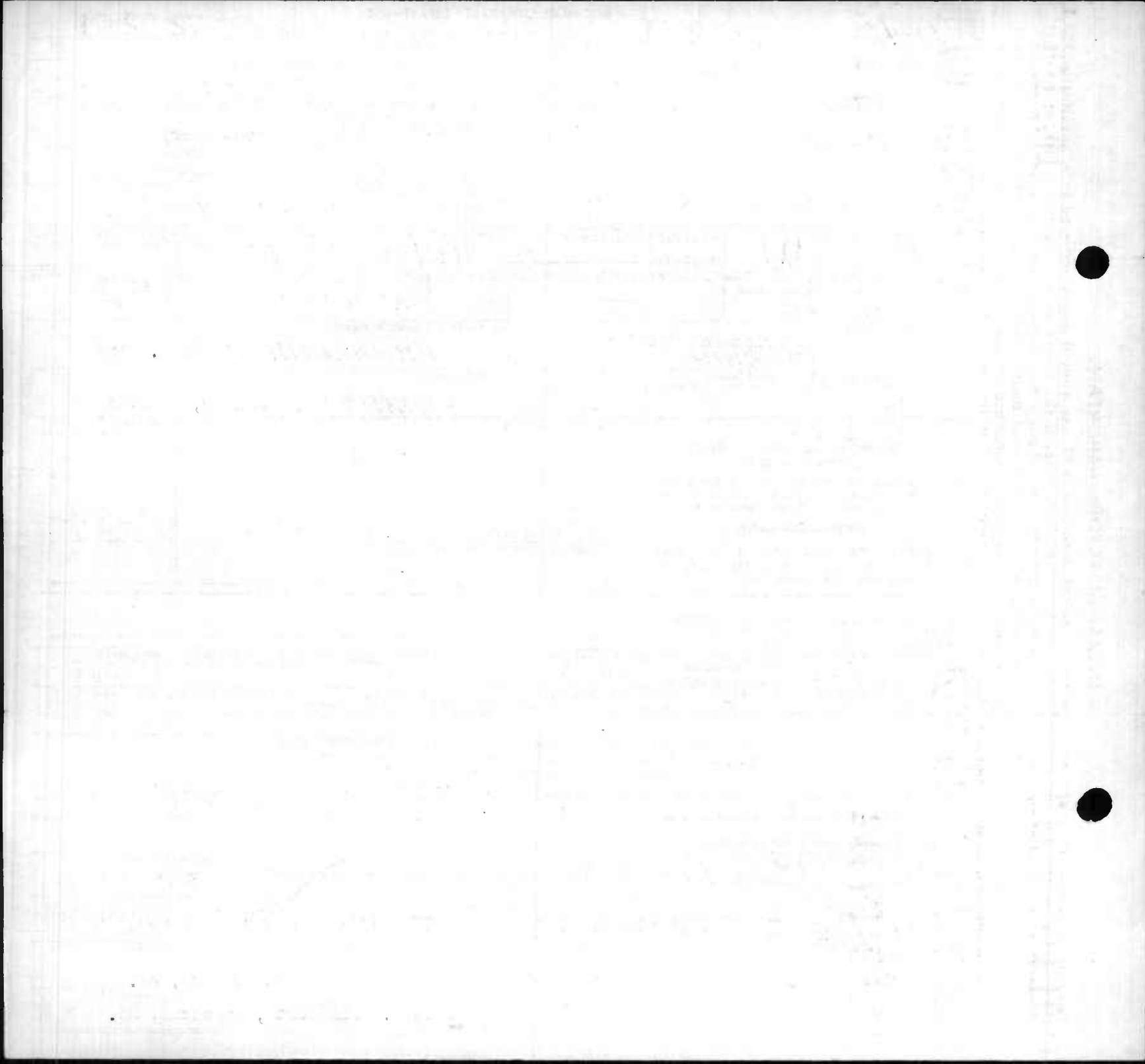
<p>D-540 72 02870</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02870</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) Donnelly, Mary Catherine</p>	
<p>2. DATE AND HOUR OF DEATH 3/18/72 12:05 A.M.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD North Charles General</p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2710</p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 49 North Charles General</p>	
<p>6. CITY OR TOWN BAH</p>		<p>7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>8. STREET AND NUMBER 5207 York Rd.</p>		<p>9. SEX F 10. RACE W 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 12. DATE OF BIRTH 12-7-01 13. AGE (in years last birthday) 70</p>	
<p>14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk</p>		<p>15. KIND OF BUSINESS OR INDUSTRY Dept. Store</p>	
<p>16. BIRTHPLACE (State or foreign country) Maryland</p>		<p>17. CITIZEN OF WHAT COUNTRY U.S.</p>	
<p>18. FATHER'S NAME FRANK Donnelly</p>		<p>19. MOTHER'S MAIDEN NAME Mary Donnelly</p>	
<p>20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>		<p>21. SOCIAL SECURITY NO. 216 03 8092A</p>	
<p>22. INFORMANT Mr. James P. Murphy 1542 Gleneagle Rd.</p>		<p>23. ADDRESS</p>	
<p>24. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2° liver metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 17 Carcinoma of colon</p>		<p>25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year years</p>	
<p>26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>27. DATE OF OPERATION 3/15/72</p>		<p>28. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>29. AUTOPSY? (Yes or No) No</p>		<p>30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>34. HOW DID INJURY OCCUR?</p>	
<p>35. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>37. I certify that (I) (this hospital) attended the deceased from 3/18/72 19 72 to 3/18 19 72 that (I) (we) last saw the deceased alive on 3/18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>38. SIGNATURE Veena Sathirakul M.D.</p>		<p>39. DATE SIGNED 3/18/72</p>	
<p>40. PHYSICIAN'S NAME (Type) VEENA SATHIRAKUL M.D.</p>		<p>41. ADDRESS NORTH CHARLES GENERAL HOSP</p>	
<p>42. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>43. DATE 3/21/72</p>	
<p>44. NAME OF CEMETERY or CREMATORY Parkwood Cemetery</p>		<p>45. LOCATION (City, town, or county) (State) Taylor Ave Balto. Md.</p>	
<p>46. DATE REC'D BY HEALTH DEPT. MAR 23 1972</p>		<p>47. NAME OF REGISTRAR Robert E. ...</p>	
<p>48. FUNERAL DIRECTOR Mitchell Wiedefeld</p>		<p>49. ADDRESS Home 6500 York Rd</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

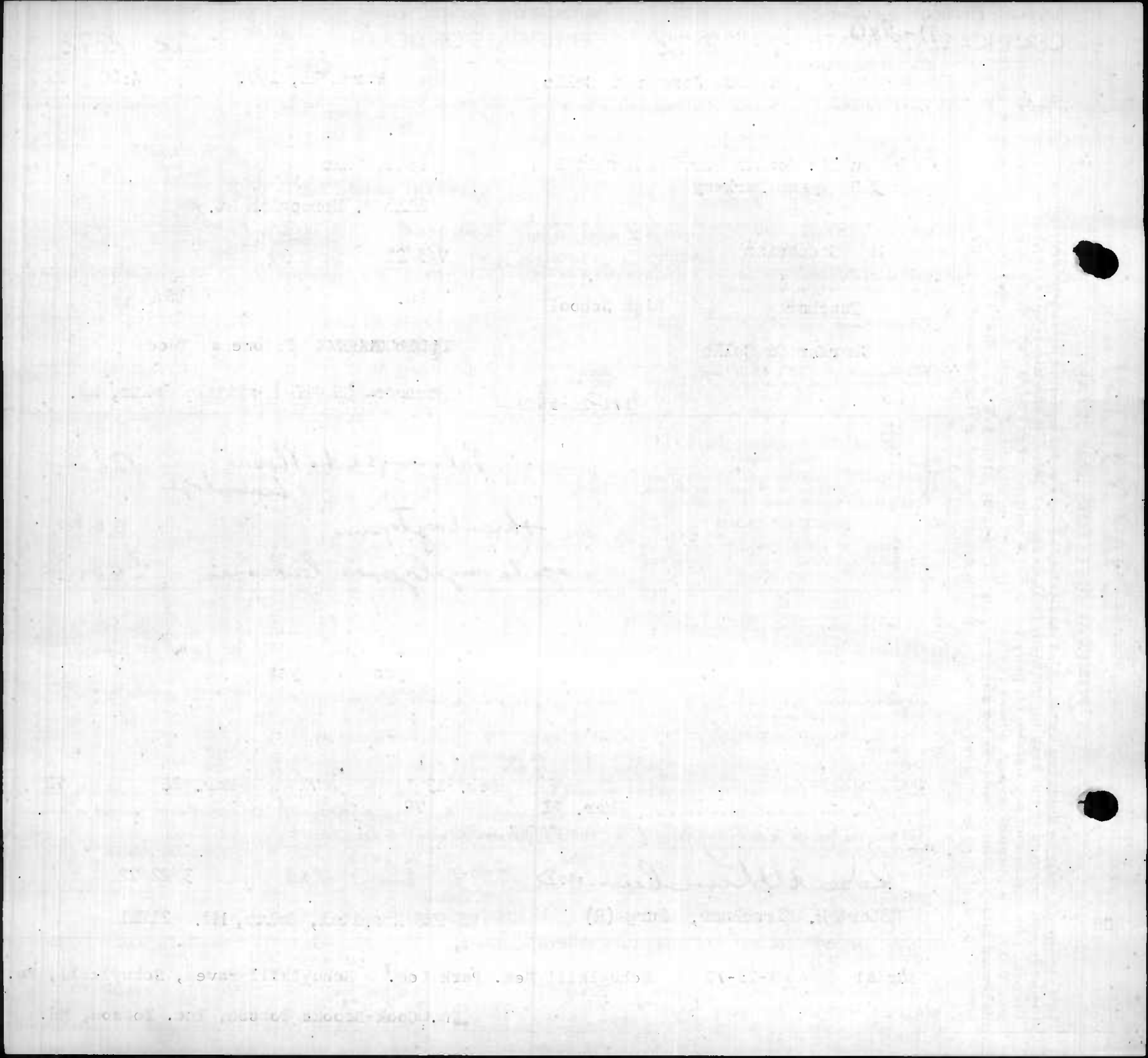
<div style="display: flex; justify-content: space-between;"> W-426 72 02871 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 02871	
BIRTH NO. W-426		2. DATE AND HOUR OF DEATH 3/19/72 8:56 P.M.	
1. NAME OF DECEASED (Type or Print) LORRAINE WALKER		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Montgomery	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN GAITHERSBURG D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 9112 ROSEMONT DRIVE	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/06
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9. AGE (In years last birthday) 65	
10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Lee Watkins	
14. MOTHER'S MAIDEN NAME MINNIE A. King		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS DECEASED Ralph Walker, Item 4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LIVER FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHOLANGIOCARCINOMA	
		(B) DUE TO, OR AS A CONSEQUENCE OF: ? years	
		(C) —	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). —			
19A. DATE OF OPERATION 3/20/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholangiocarcinoma	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 1/16/72 19 3/19/72 19 3/19 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Georg J. Berakha MD		23B. DATE SIGNED 3/19/72	
23C. PHYSICIAN'S NAME (Type) GEORGE J. BERAKHA MD		23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/72	
24C. NAME OF CEMETERY OR CREMATORY Forest Oak		24D. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR John E. ...	
25C. FUNERAL DIRECTOR Oliver L. ...		ADDRESS Damascus, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

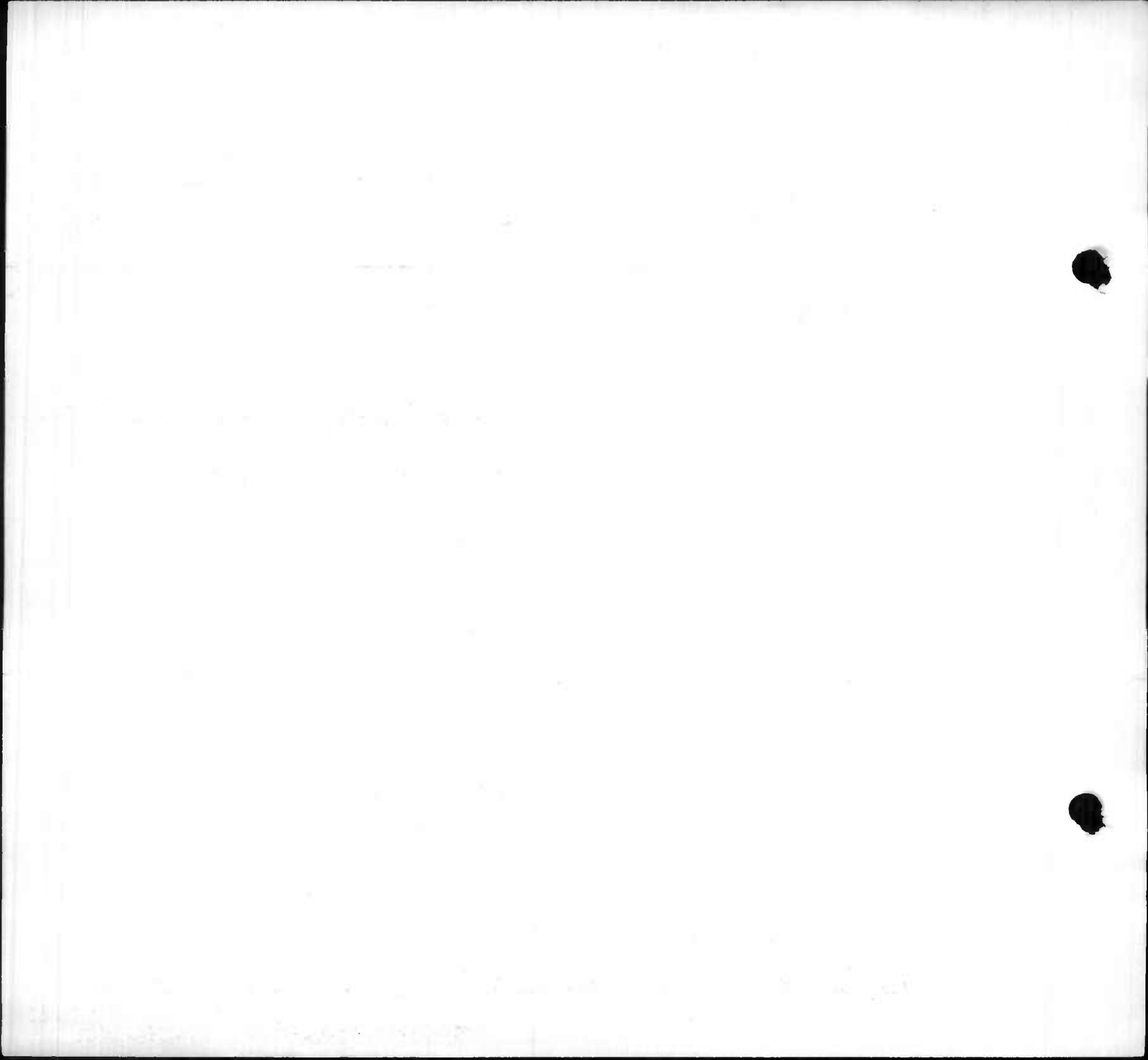
BALTIMORE CITY HEALTH DEPARTMENT										
72 02872					CERTIFICATE OF DEATH		REG. NO. 72 02872			
1. NAME OF DECEASED (Type or Print) Raphael Joseph Di Cello					2. DATE AND HOUR OF DEATH March 21, 1972 4:20 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY V35					
5. SEX M 6. RACE Caucasian 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 7/5/32		9. AGE (In years last birthday) 39		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Pa.					12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles Di Cello					14. MOTHER'S MAIDEN NAME Filomena Tucci					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 171-26-5889		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH										
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>205.01</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary & intra-thoracic hemorrhage</p> <p>(B) thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) acute myelogenous leukemia</p> </div> <div style="width: 35%;"> <p>12 hours</p> <p>6 wks</p> <p>3-6 weeks</p> </div> </div>										
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>19A. DATE OF OPERATION 2</p> </div> <div style="width: 30%;"> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> </div> <div style="width: 30%;"> <p>20A. AUTOPSY? (Yes or No) yes</p> </div> <div style="width: 30%;"> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> </div> <div style="width: 45%;"> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> </div> <div style="width: 45%;"> <p>21F. HOW DID INJURY OCCUR?</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> </div> <div style="width: 45%;"> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> </div> </div>										
<p>22. I certify that (I) (this hospital) attended the deceased from Feb. 13 19 72 to Mar. 21 19 72, that (I) (we) last saw the deceased alive on Mar. 21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 70%;"> <p>23A. SIGNATURE Robert H. Kirschner MD</p> </div> <div style="width: 30%;"> <p>23B. DATE SIGNED 3/22/72</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 55%;"> <p>23C. PHYSICIAN'S NAME (Type) Robert H. Kirschner, Surg (R)</p> </div> <div style="width: 45%;"> <p>23D. ADDRESS US PHS Hospital, Balto, Md. 21211</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> </div> <div style="width: 30%;"> <p>24B. DATE 3-25-72</p> </div> <div style="width: 30%;"> <p>24C. NAME OF CEMETERY or CREMATORY Schuylkill Mem. Park Cem.</p> </div> <div style="width: 30%;"> <p>24D. LOCATION (City, town, or county) (State) Schuylkill Haven, Schuylkill, Pa.</p> </div> </div>										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972</p> </div> <div style="width: 30%;"> <p>25B. NAME OF REGISTRAR 366322722 0 0 0</p> </div> <div style="width: 40%;"> <p>25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Inc, Towson, Md.</p> </div> </div>										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02873	
1. NAME OF DECEASED (Type or Print) LULA MOODY		2. DATE AND HOUR OF DEATH Mar. 20, 1972 12:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 3001 S. Harwood Baltimore, Maryland 21230				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto Co. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 7434 Berkshire Rd. 21222			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-93	9. AGE (In years last birthday) 78 yrs	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James F Lloyd				14. MOTHER'S MAIDEN NAME Annie Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-14-3295-A		17. INFORMANT JAMES F JAMES, 7434 BERKSHIRE RD. 21222			
18. 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of the pancreas - metastatic				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Sambiti							
19A. DATE OF OPERATION Mar. 3, 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Jaundice 2° biliary obstruction		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 21, 1972 to Mar. 20, 1972 that (I) (we) last saw the deceased alive on Mar. 20, 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roberto R. Canizares M.D.				23B. DATE SIGNED Mar. 20, 1972		23C. PHYSICIAN'S NAME (Type) ROBERTO R. CANIZARES M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVED TO MARTIN LUTHER KING JR. CEMETERY				24B. DATE MAR 23 1972		24C. NAME OF CEMETERY OR CREMATORY MARTIN LUTHER KING JR. CEMETERY	
24D. LOCATION (City, town, or county) (State) RAINWOOD, VIRGINIA				25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972			
25B. NAME OF REGISTRAR Robert E. Jones, M.D.				25C. FUNERAL DIRECTOR Charles E. Jones, M.D.			



BIRTH NO.		72 02874		BALTIMORE CITY HEALTH DEPARTMENT		72 02874	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print)		TERRY RYAN McCARTY TERRY MC CARTY		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month Day Year Hour March 14, 1972 3:43 P. M.	
00 1907 E. 30th Street				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
				Maryland		906	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male	White			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years lost birthday)	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
4/26/49	29	CALIFORNIA		USA		Edward L. McCARTY	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
U.S. NAVY		Armed Forces		UNKNOWN			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
yes VICT NAM		489-54-1465		US GOVERNMENT		Records	
19. E 9551X		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Gunshot wound of mouth			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B)		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
0				No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
		Home		1907 E. 30th Street		906	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
March (?) 1972(?)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Shot self			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		Charles S. Springate M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		March 15, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
CREMATION		3/21/72		Loudon PK. Cem		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 23 1972		J. B. ...		Sept 2, Funeral Home		York Rd	
						Baltimore Md	

TO THE
MEDICAL BOARD
OF THE
ARMY
OF THE
UNITED STATES
OF AMERICA
WASHINGTON, D. C.
20315
SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. H. [Signature]

NEW CRIPPER 1800 CHARACTERS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-340		72 02875		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02875	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Arthur W. Steele</u>				2. DATE AND HOUR OF DEATH <u>3/20/72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2506</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12-9-10</u>		9. AGE (in years last birthday) <u>61</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rough Painter</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
13. FATHER'S NAME <u>Arthur W. Steele Sr.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>249-16-9790</u>		17. INFORMANT <u>Jerry Bryant</u>	
18. <u>162.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>12-10-41</u> 19 <u>41</u> to <u>3-20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3-20-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Dr. Lourdes M. Victoria</u> DEGREE 23B. DATE SIGNED <u>3-20-72</u> 23C. PHYSICIAN'S NAME (Type) <u>LOURDES M. VICTORIA</u> DEGREE 23D. ADDRESS <u>Lutheran Hospital of Maryland</u> <u>730 Ashburton St. BALTO. MD. 21216</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>3 25 72</u> 24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary</u> 24D. LOCATION (City, town, or county) (State) <u>A. A County Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1972</u> 25B. NAME OF REGISTRAR <u>Rebecca J. ...</u> 25C. FUNERAL DIRECTOR <u>L. Brown</u> ADDRESS <u>0123 W. Montgomery St.</u>							

1914

1. The first of the year was a very dry one.

2. The second of the year was a very wet one.

3. The third of the year was a very dry one.

4. The fourth of the year was a very wet one.

W-325

72 02876 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02876

BIRTH NO.

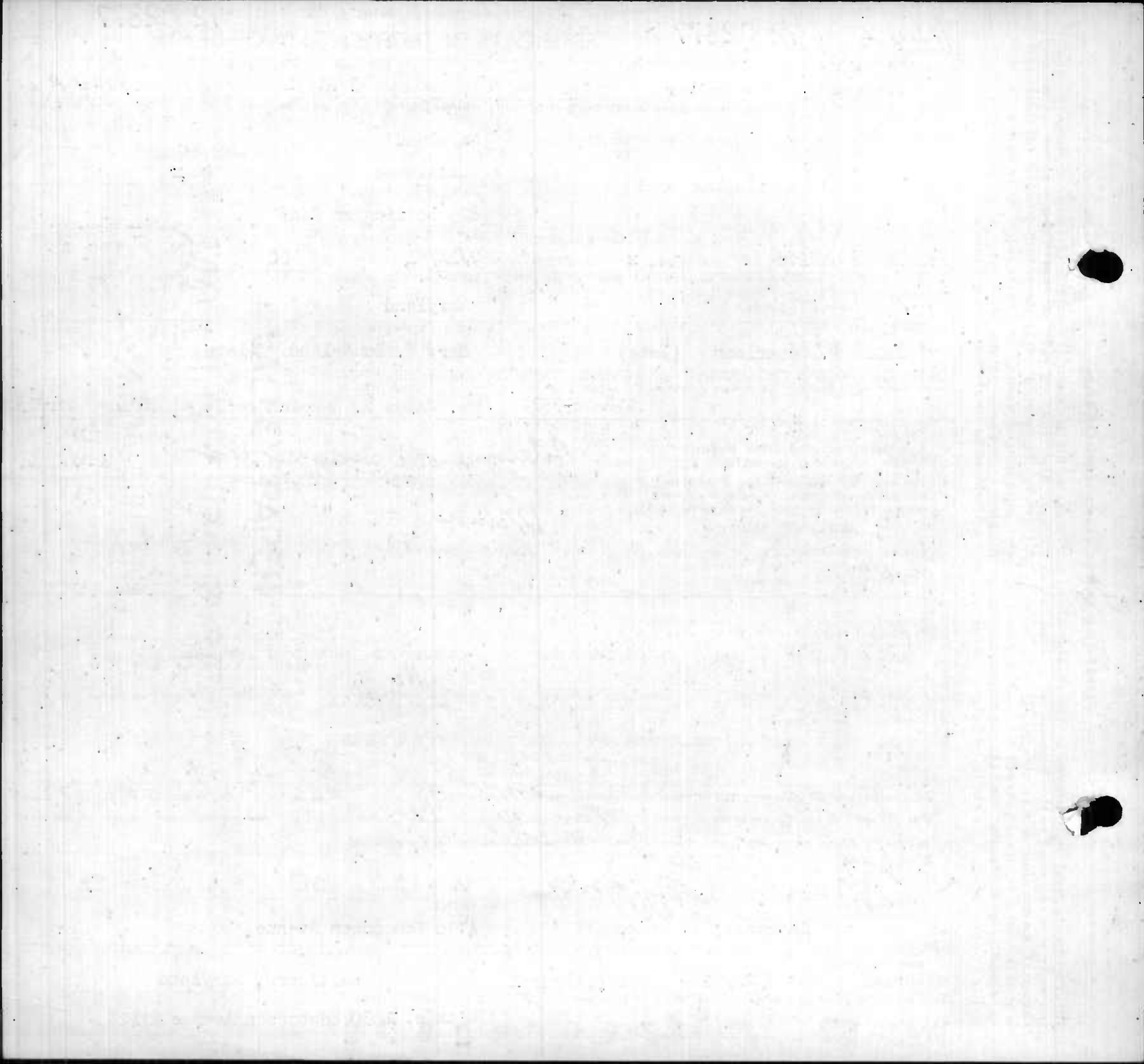
1. NAME OF DECEASED (Type or Print) ALBERT WATSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1113 S. Sharp Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 19, 1972 7:30 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 64		E. STREET AND NUMBER 1113 S. Sharp Street	
11. BIRTHPLACE (State or foreign country)		13. FATHER'S NAME	
12. CITIZEN OF WHAT COUNTRY? US		15. MOTHER'S MAIDEN NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214 69-6498	
18. INFORMANT		ADDRESS	
19. 571.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (Partial)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) OF INJURY		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		3-22-72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
W. Calvary		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
MAR 23 1972		Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Edmondson		23 Edmondson	

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

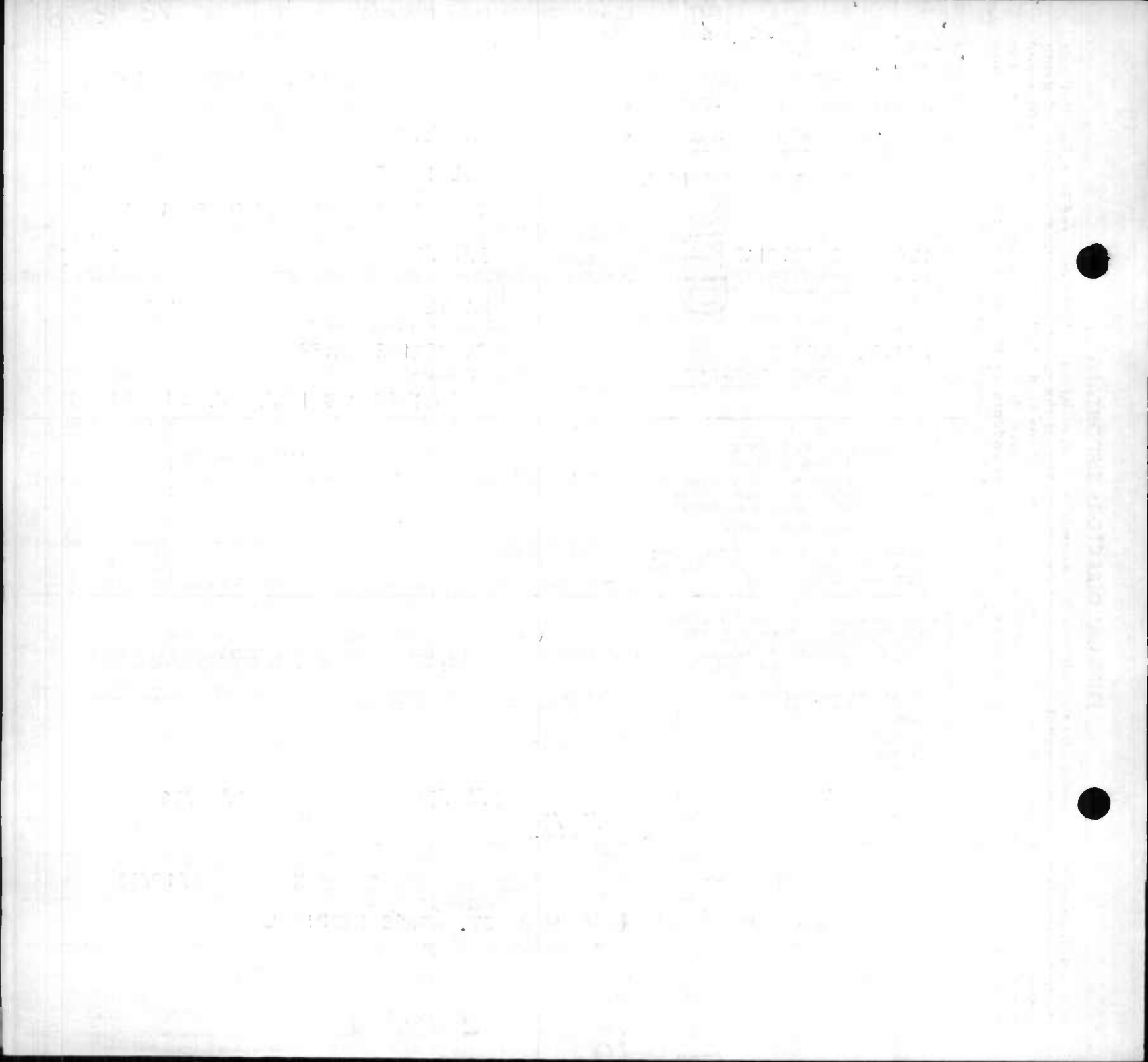
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02877	
BIRTH NO. W-426 72 02877				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Frances Blanche Walker			2. DATE AND HOUR OF DEATH 3/21/72 8:45 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 623 Nottingham Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2834 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 623 Nottingham Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/91	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W-395 12 1 1987			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Alexis P. Sauerland (late)			14. MOTHER'S MAIDEN NAME Mary V. Sauerland (late)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-46-3531		17. INFORMANT ADDRESS Mrs. James L. Hampson 6516 Woodbridge Circle
18. 404 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Arteriosclerotic CardioVasc. Renal Disease (A) IMMEDIATE CAUSE DUE TO, OR AS, A CONSEQUENCE OF: Uremia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Mar. 9, 1963 to Mar. 22, 1972 , that (I) (we) last saw the deceased alive on Mar. 22, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp			23B. DATE SIGNED 3-22-72		
23C. PHYSICIAN'S NAME (Type) Dr. Harry L. Knipp			23D. ADDRESS 4116 Edmondson Avenue 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/72	24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR Witzke, 1630 Edmondson Avenue 21228		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228	



FUNERAL DIRECTOR: IMPORTANT

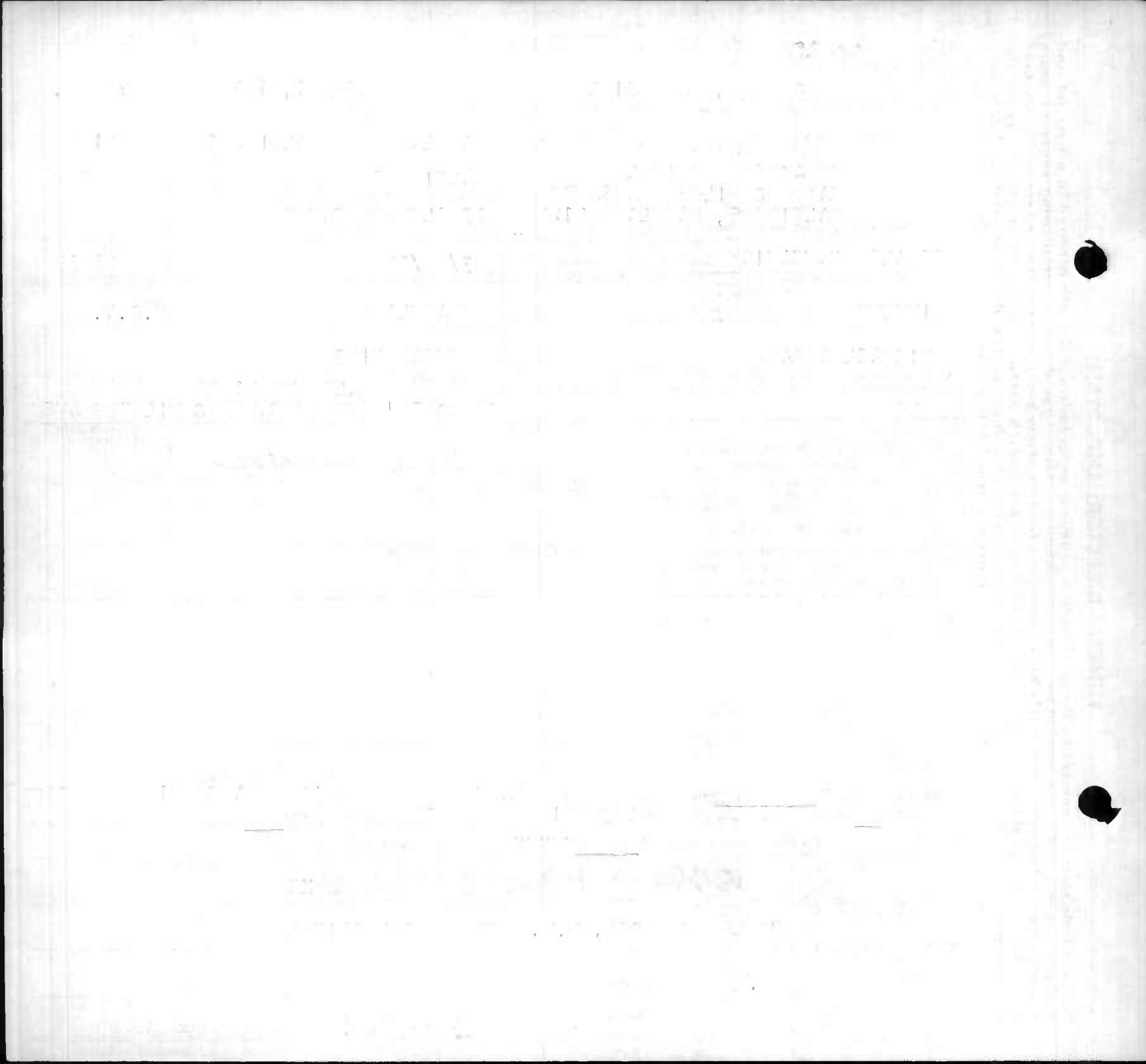
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-325</u> <u>72 02878</u>				BALTIMORE CITY HEALTH DEPARTMENT		72 02878	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		REG. NO.	
WATSON BABY BOY				MARCH 18, 1972		7:40AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
40 ST AGNES HOSPITAL				MARYLAND BALTO 5300			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				1448 FOREST PARK AVENUE 21207			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
MALE		CAUCASIAN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		03/18/72	
						9. AGE (In years last birthday)	
						11 Under 1 Yr. Months: Days: 7 3	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NEWBORN						MARYLAND	
12. CITIZEN OF WHAT COUNTRY?				U S A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
MICHAEL WATSON				CATHERINE PFAFF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						ST AGNES HOSPITAL BALTO MD 21229	
18. <u>75-9-1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				<i>multiple congenital anomalies</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>2</u>				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that X (X) (this hospital) attended the deceased from <u>03/18/72</u> 19 to <u>03/18/72</u> 19 that X (X) (we) last saw the deceased alive on <u>03/18/72</u> 19 and that in X (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) X (X) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED		3/19/72	
23C. PHYSICIAN'S NAME (Type) <u>RODOLFO P. VELASCO M.D.</u>				23D. ADDRESS		ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3/20/72		Glen Haven		Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 23 1972		[Signature]		Mitake, 71630		Edmondson Avenue 21228	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-165 BIRTH NO. 72-057612879		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 02879	
1. NAME OF DECEASED (Type or Print) ABRAMO, BABY GIRL			2. DATE AND HOUR OF DEATH MARCH 21, 1972 6:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 21228 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 13 ELKWOOD COURT 5300		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/20/72	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME MICHAEL ABRAMO		
14. MOTHER'S MAIDEN NAME SUSAN KING			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 772.01 Cerebral hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MARCH 20 19 72 to MARCH 21 19 72 that (0) (we) last saw the deceased alive on MARCH 21 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Rudolfo Valasco			23B. DATE SIGNED M.D.		23C. PHYSICIAN'S NAME (Type) RODOLFO VALASCO, M.D.
23D. ADDRESS ST AGNES HOSPITAL			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 3/23/72			24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		
24D. LOCATION Baltimore, Maryland			24E. DATE REC'D BY HEALTH DEPT. MAR 23 1972		
24F. NAME OF REGISTRAR Wm. H. Edmondson			25. FUNERAL DIRECTOR Edmondson Avenue 21228		



BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

DENNIS LEE BROWN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

48

MARYLAND GENERAL HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 21, 1972

11:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1403

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1-22-50

10. AGE (In years
lost birthday)

22

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1911 Etting Street

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Veno Brown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Thelma Perkins

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

Thelma Brown

ADDRESS

same

19.

E965X1

CAUSE OF DEATH

Gunshot wound of chest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1500 Blk. Division Street

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY
(APPROX.)

3-21-72

10:45 P

m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/22/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-26-72

24C. NAME of CEMETERY or CREMATORY

Family Plot

24D. LOCATION (City, town, or county) (State)

Greenville, N.C.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

Kelson F. H. 1348 Calhoun Street

U.S. 88

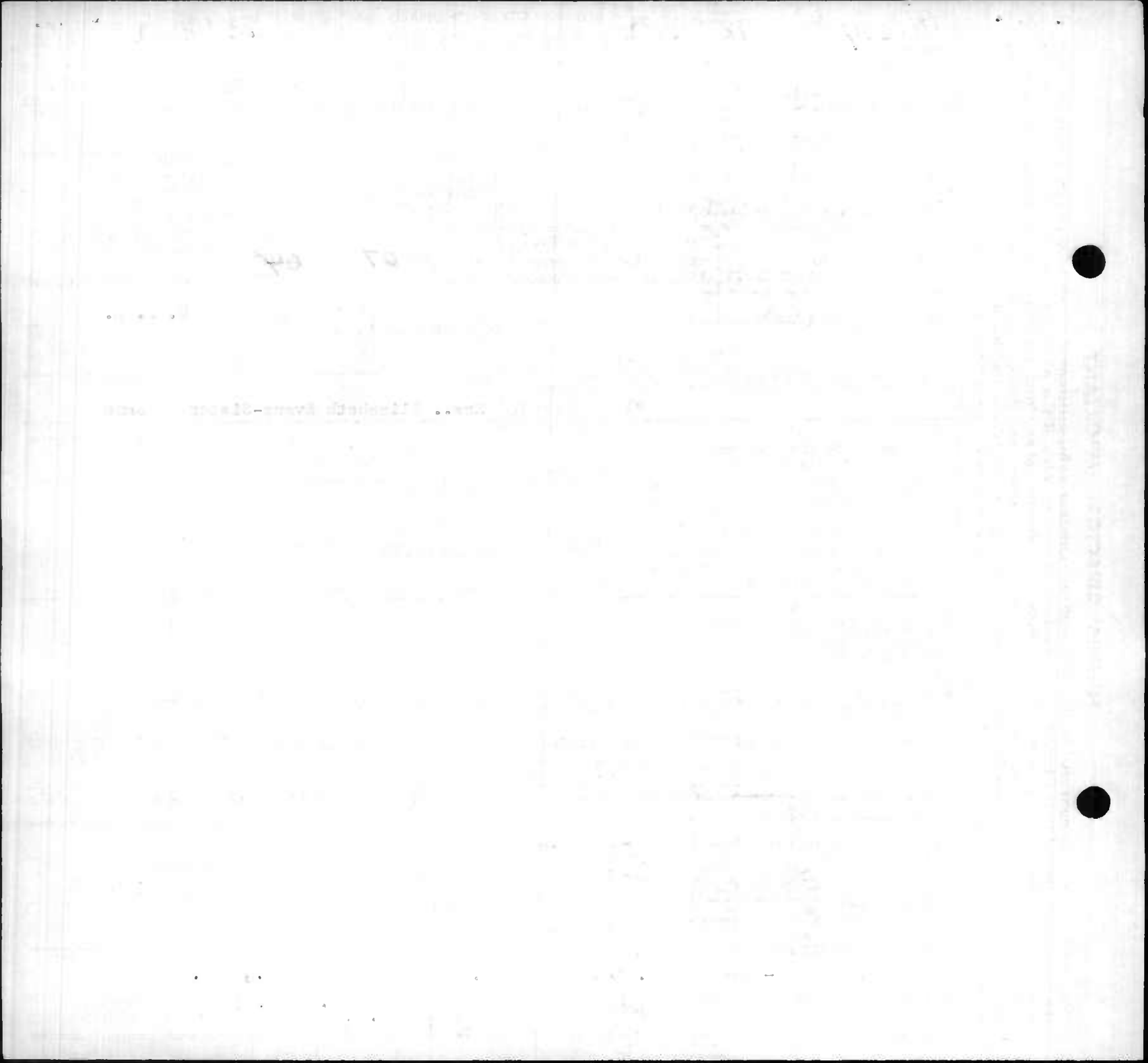
VALLEY REGION

1990/1991

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

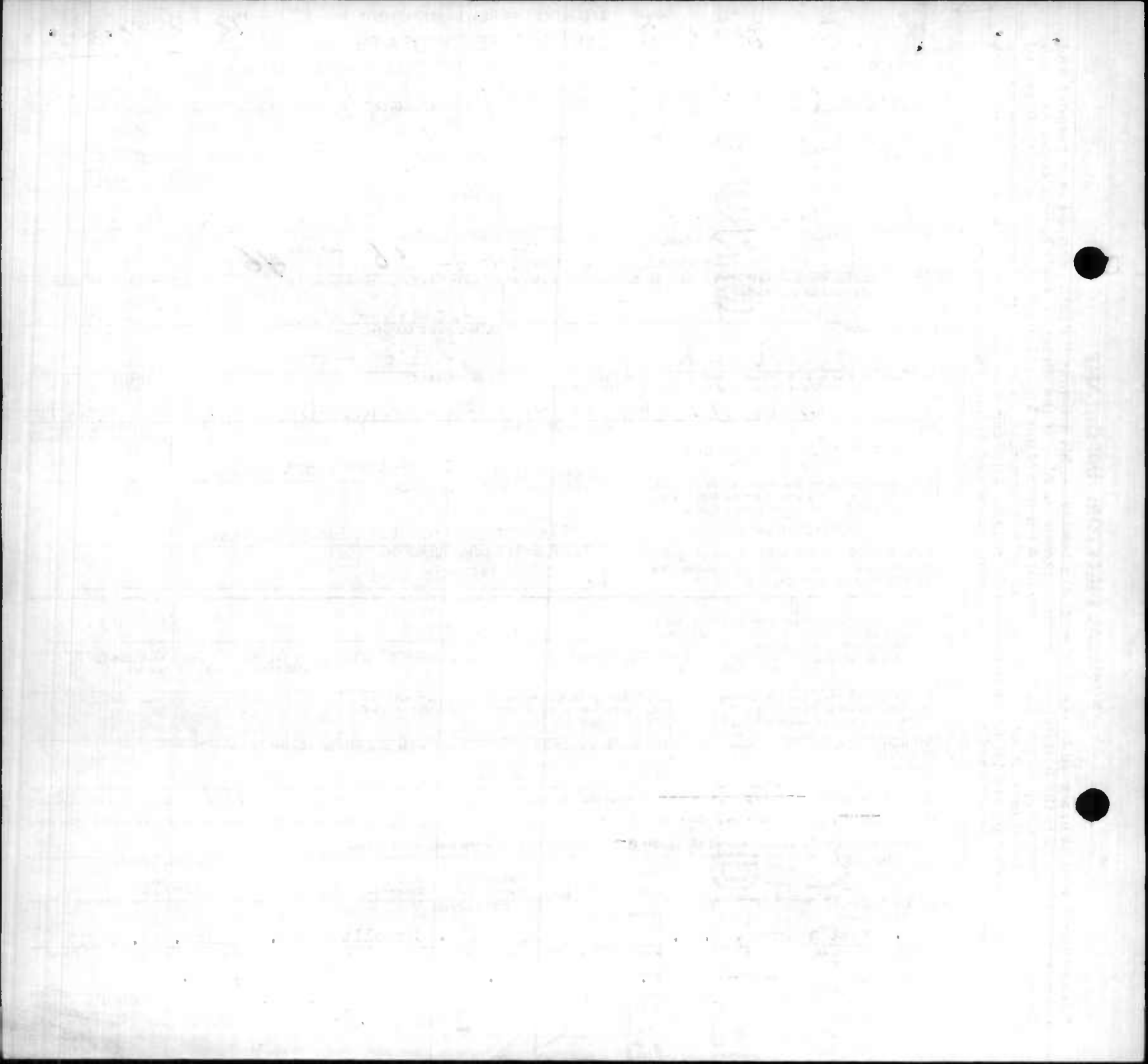
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02881</p>	
<p>BIRTH NO. M-624</p>		<p>72 02881</p>	
<p>1. NAME OF DECEASED (Type or Print) Morsell Theron</p>		<p>2. DATE AND HOUR OF DEATH 3-21-72 8:10 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 2600 Liberty Heights Ave.</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Maryland B. COUNTY 1510</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 3815 Cold Spring Lane</p>	
<p>5. SEX M</p>	<p>6. RACE N</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 10-19-07</p>
<p>9. AGE (In years last birthday) 64</p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
<p>13. FATHER'S NAME Ruffus Morsell</p>		<p>14. MOTHER'S MAIDEN NAME Viola Albright</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no; branch) (If yes, give war or dates of service) no</p>		<p>16. SOCIAL SECURITY NO. 911-18-8190</p>	
<p>17. INFORMANT Mrs.. Elizabeth Evans-Sister</p>		<p>ADDRESS Same</p>	
<p>18. 431.9 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA probable Cerebral Hemorrhage</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>19. DATE OF OPERATION 0</p>		<p>20. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 3-19 19 72 to 3-21 19 72 that (I) (we) last saw the deceased alive on 3-21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Mauricio Coto</p>		<p>23B. DATE SIGNED 3-21-72</p>	
<p>23C. PHYSICIAN'S NAME (Type) M. G. Mercado MD</p>		<p>23D. ADDRESS Provident Hosp. Balt. Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3-25-72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.</p>		<p>24D. LOCATION (City, town, or county) (State) Balto., Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972</p>		<p>25B. NAME OF REGISTRAR Kelson F.H.</p>	
<p>25C. FUNERAL DIRECTOR V. Bailey</p>		<p>ADDRESS 1348 Calhoun Street</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02882</u>	
D-612: 72 02882		CERTIFICATE OF DEATH			
BIRTH NO. <u>72 02882</u>					
1. NAME OF DECEASED (Type or Print) <u>Lucien Derbigny</u>		2. DATE AND HOUR OF DEATH <u>2/2/72</u>		Undetermined	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		A. STATE <u>Md.</u>		B. COUNTY <u>1001</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1114 Homewood Ave</u>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1114 Homewood Ave</u>			
5. SEX <u>M.</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-56</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Derbigny</u>		14. MOTHER'S MAIDEN NAME <u>Nellie —</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.T.</u>		16. SOCIAL SECURITY NO. <u>435306674</u>		17. INFORMANT <u>Gwendolyn Derbigny</u>	
18. <u>753.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Bilateral Polycystic Kidney Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Undetermined</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Undetermined</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examination) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/27/72</u> to <u>1/27/72</u> that (I) (we) last saw the deceased alive on <u>1/27/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Preston Grant</u>		23B. DATE SIGNED <u>2/4/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>J. Preston Grant, M. D.</u>		23D. ADDRESS <u>601 N. Carrollton Ave. Balto. Md. 21217</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-23-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1972</u>		25B. NAME OF REGISTRAR <u>Delbon, F.F.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>	
25D. ADDRESS <u>1348 Calhoun Street</u>					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOHN J. MANNING		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 21 , Year 1972 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month March Day 21 , Year 1972 Hour 4:45 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/17/1908		10. AGE (In years last birthday) 64	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		14B. KIND OF BUSINESS OR INDUSTRY U.S. Army	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 212-54-7552	
15. MOTHER'S MAIDEN NAME Elizabeth		18. INFORMANT V.A. Records	
19. E890X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Smoke inhalation ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Conflagration OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3510 Hayward Avenue		22D. TIME OF INJURY (APPROX.) 3-21-72	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found in burning house	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. DATE SIGNED March 21, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/24/1972	
24C. NAME OF CEMETERY or CREMATORY Culpeper National Cem.		24D. LOCATION (City, town, or county) (State) Culpeper, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR Robert E. Johnson, M.D.	
25C. FUNERAL DIRECTOR Wm. E. Johnson		ADDRESS 8521 Loch Raven Blvd. 21204	

VALLEY PAPER CO

400 CONTENT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02884		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02884	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>SUSIE B. TUCKER</u>			2. DATE AND HOUR OF DEATH <u>3/15/72</u> <u>1:05 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MD. GENERAL HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1401</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1400 JOHN ST.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/90</u>	9. AGE (in years last birthday) <u>81</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Godfrey Tucker</u>		
14. MOTHER'S MAIDEN NAME <u>Elizabeth Bank</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>212-03-0941</u>			17. INFORMANT <u>Hospital Record Mr. George Washington 10154 Lemay St</u>		
18. <u>4/12/41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Atherosclerotic cardiovascular disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> 19 <u>72</u> to <u>3/15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard H. Balcer M.D.</u>			23B. DATE SIGNED <u>3/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD H. BALCER. M.D.</u>
23D. ADDRESS <u>Md. Gen. Hospital</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>Mar 20 1972</u>			24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem Park</u>		
24D. LOCATION <u>Arbutus</u>			24E. LOCATION (City, town, or county) (State) <u>MD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		
25C. FUNERAL DIRECTOR <u>2877 Russ</u>			25D. ADDRESS <u>2222 W. North Ave</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02885		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02885	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Frazier, James A.</i>		2. DATE AND HOUR OF DEATH <i>3/21/72 18:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>49 North Charles Gen. Hosp. 2224 N. Charles St.</i>				E. STREET AND NUMBER <i>7215 Orpe Rd.</i>	
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/13/38</i>	9. AGE (In years last birthday) <i>33</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher, Boys' School</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bus. Education</i>		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>James Amos Frazier</i>			
14. MOTHER'S MAIDEN NAME <i>Leola Mathews</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hosp. Chart</i>			
18. <i>162-1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Shock + cardiorespiratory arrest</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cancer of the lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-17</i> 19 <i>72</i> to <i>3-21</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>3-21</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. Ignacio, M.D.</i>		23B. DATE SIGNED <i>3/21/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Narciso E. Ignacio M.D.</i>	
23D. ADDRESS <i>North Charles Gen. Hosp. Balto, Md.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>3-25-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arboretum</i>		24D. LOCATION (City, town, or county) (State) <i>Arboretum Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 23 1972</i>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>B. W. Wilson</i>	
ADDRESS <i>1000 B. Hwy. 1</i>					

7215 ORTH RD

7215 ORTH RD
J. B. Smith - 2140 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T

1944

1944

Y

1944

1944

1944

1944

1944

1944

1944

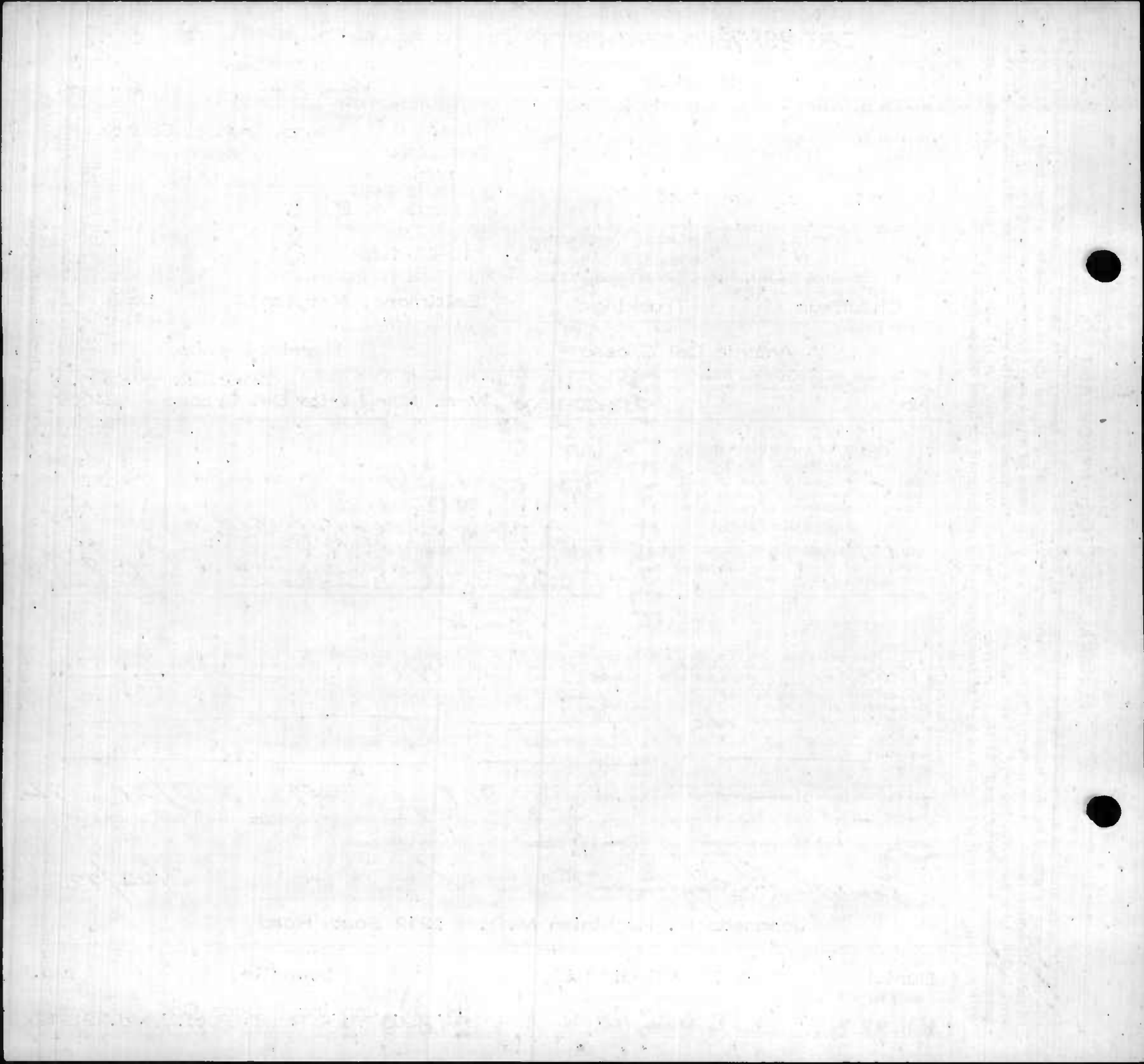
1944

1944

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02887				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02887	
BIRTH NO. 72 02887				CERTIFICATE OF DEATH		REG. NO. 72 02887	
1. NAME OF DECEASED (Type or Print) Maria Grace Breeback				2. DATE AND HOUR OF DEATH 3/22/72 6 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Anne Arundel County 5200			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2316 Sulgrave Road				C. CITY OR TOWN Arnold		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER Route 4 Box 53							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-28-1933	9. AGE (In years lost birthday) 38	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antonio Del Grosso				14. MOTHER'S MAIDEN NAME Harriet Heslop			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-30-8500		17. INFORMANT 2316 Sulgrave Rd. Mrs. Margherita Del Grosso 21209			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CACHEXIA DUE TO, OR AS A CONSEQUENCE OF: (B) METASTATIC CARCINOMA OF LIVER + LUNGS DUE TO, OR AS A CONSEQUENCE OF: (C) SQUAMOUS CELL CARCINOMA OF GASTROBLADDER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 6 Mos 6-8 Mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 3/16/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ENLARGED LIVER		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/9 1959 to 3/21 1972, that (I) (we) last saw the deceased alive on 3/21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Jeannette R. Heghinian, M.D.				23B. DATE SIGNED 3/22/72		23C. PHYSICIAN'S NAME (Type) Jeannette R. Heghinian M.D. 2212 South Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-23-72		24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR J. E. Taylor		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 2400 York Road Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B6511

72 02888

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

72 02888

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED KINGSTON BURNAFORD

2. DATE AND HOUR OF DEATH

Mar. 21, 1972 9:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

US Public Health Service Hospital
3100 Wyman Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Penna. Luzerne

C. CITY OR TOWN

Dallas

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

Route 3 Box 416 Country Club Road

5. SEX

F

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12/28/36

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa. Wilkes-Barre

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Kingston

14. MOTHER'S MAIDEN NAME

Anna Gdovin

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

173-30-6100

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18.

485X 1-200.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Bilateral bronchopneumonia

Days

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

Malignant lymphoma (verriculum cell)

6 mos.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
Work

Not While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar. 15 19 72 to Mar. 21 19 72,
that (I) (we) last saw the deceased alive on Mar. 21 19 72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert E. Belliveau, M.D.

23B. DATE SIGNED

3/21/72

23C. PHYSICIAN'S
NAME (Type)

Robert E. Belliveau, Surg (R)

23D. ADDRESS

US PHS Hospital, Balto, Md. 21211

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/24/72

24C. NAME OF CEMETERY or CREMATORY

Chapel Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Dallas, Luzerne Co., Penna.

25A. DATE REC'D BY HEALTH DEPT.

MAR 23 1972

25B. NAME OF REGISTRAR

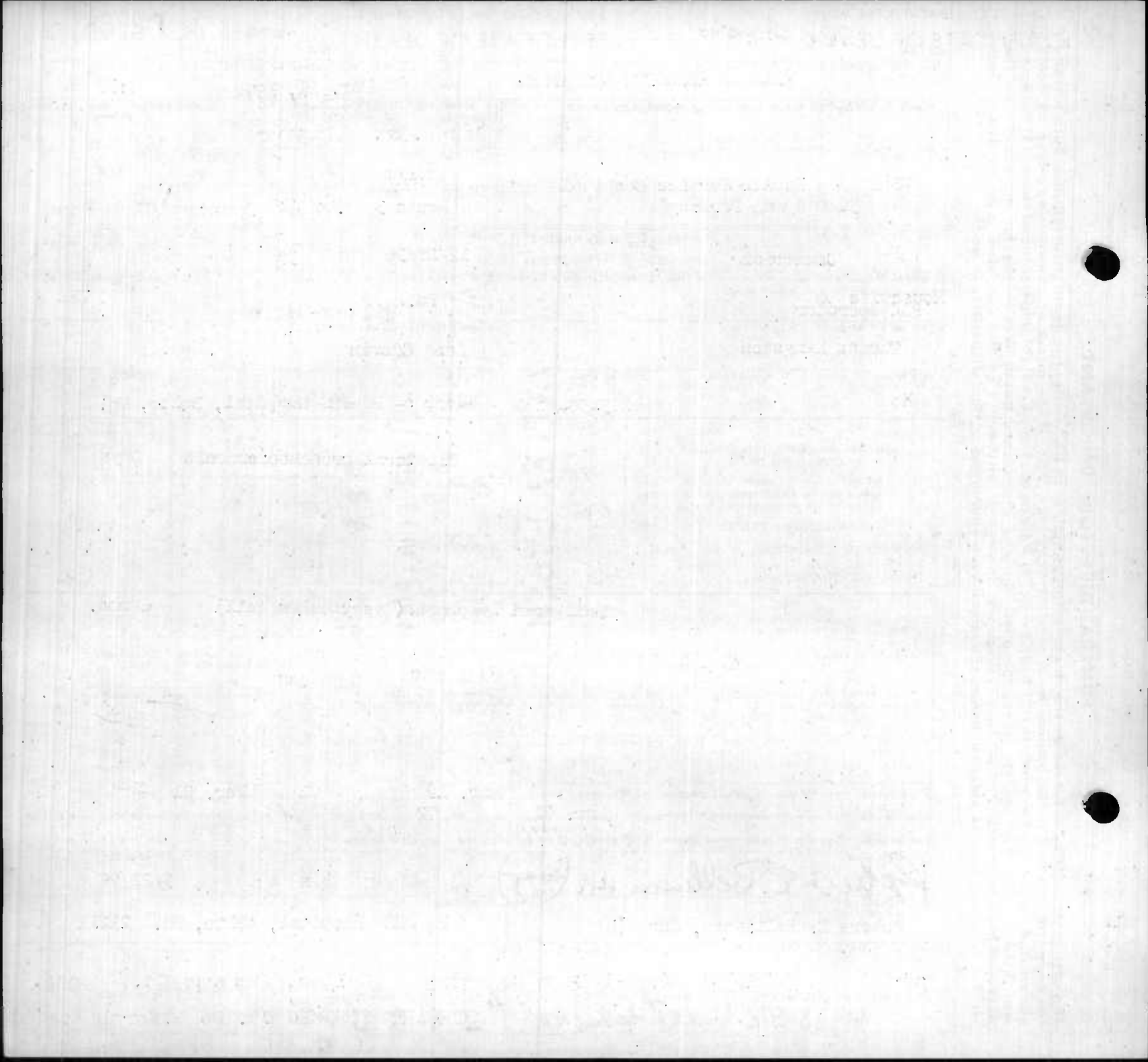
Robert E. Belliveau, M.D.

25C. FUNERAL DIRECTOR

STEDART & MOWEN

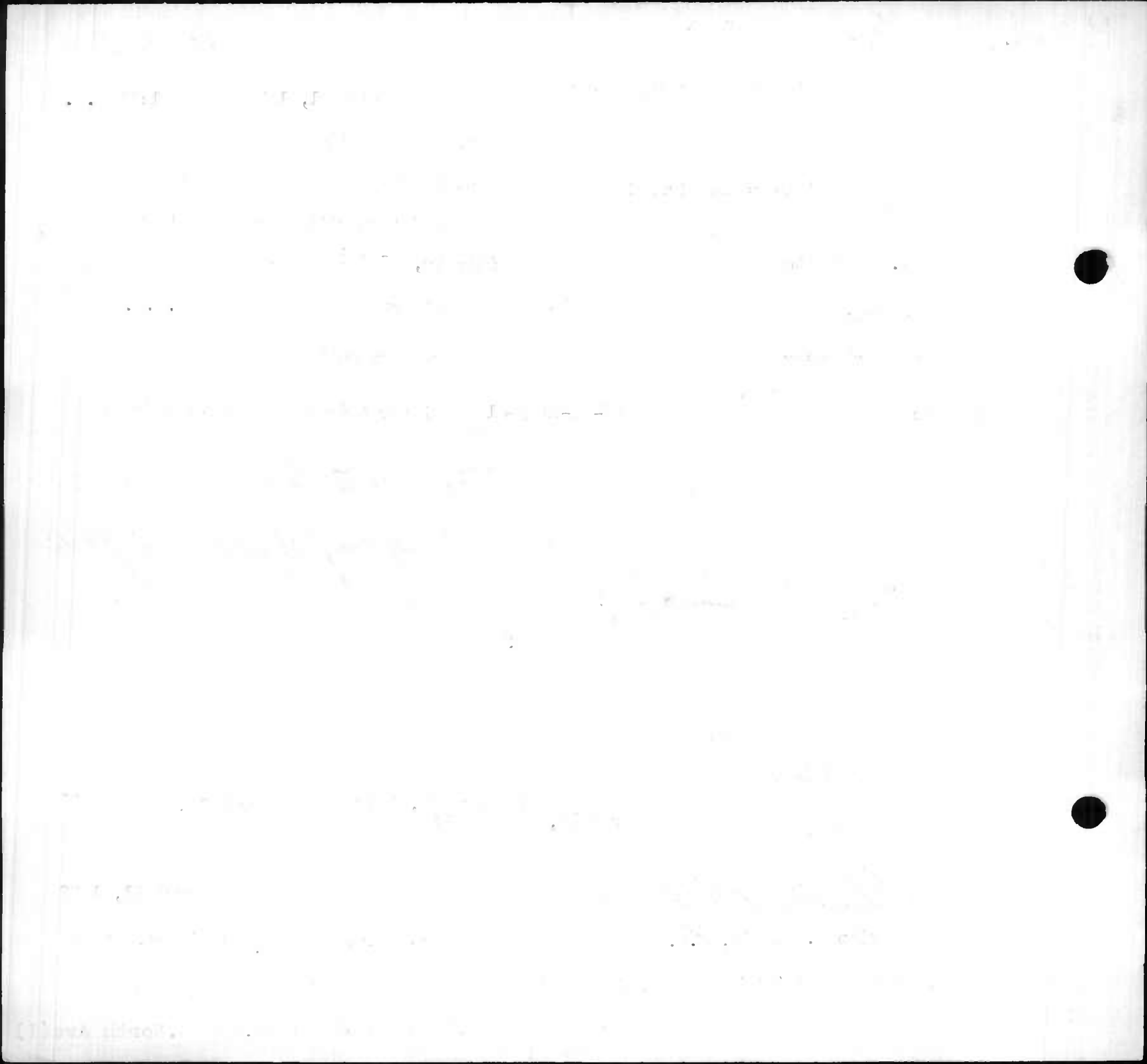
ADDRESS

CO. 108 W. North Ave (1)



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02889		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02889	
1. NAME OF DECEASED (Type or Print) Sister Bernardine Buser		2. DATE AND HOUR OF DEATH March 21, 1972 1:17 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City 2831			
5. SEX F.		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Bernard Buser		14. MOTHER'S MAIDEN NAME Mary Lucy Muth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-54-4133-1		17. INFORMANT Sister Andrea same address	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of breast (B) DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma of breast (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) No injury		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 14, 1972 to March 14, 1972 that (I) (we) last saw the deceased alive on March 14, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Damian P. Alagia, M.D.		23B. DATE SIGNED March 21, 1972		23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME OF CEMETERY or CREMATORY St. Joseph's Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR STEWART & NOWEN CO. 108 W. North Ave (1)	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-450 72 02890		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02890	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		FALLON, GERTRUDE EVELYN		2. DATE AND HOUR OF DEATH MARCH 18, 1972 10:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		MARYLAND BALTIMORE 21229 5300	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1039 BEECHFIELD AVENUE		5. SEX FEMALE		6. RACE CAUCASIAN	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09/23/98		9. AGE (In years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME GERTRUDE HARRIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT WILKENS AVENUES 21229 ST AGNES HOSPITAL'S RECORDS CATON &	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia. Rt. upper lobe Arteriosclerotic Heart Disease Diabetes Mellitus		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from MARCH 11 19 72 to MARCH 18 19 72 that (we) last saw the deceased alive on MARCH 18 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.			
23A. SIGNATURE M. Yousuf Siddiqui		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) M. YOUSUF SIDDIQUI, M.D.	
23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-1972	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972	
25B. NAME OF REGISTRAR Robert H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

James M. Smith

Director of the

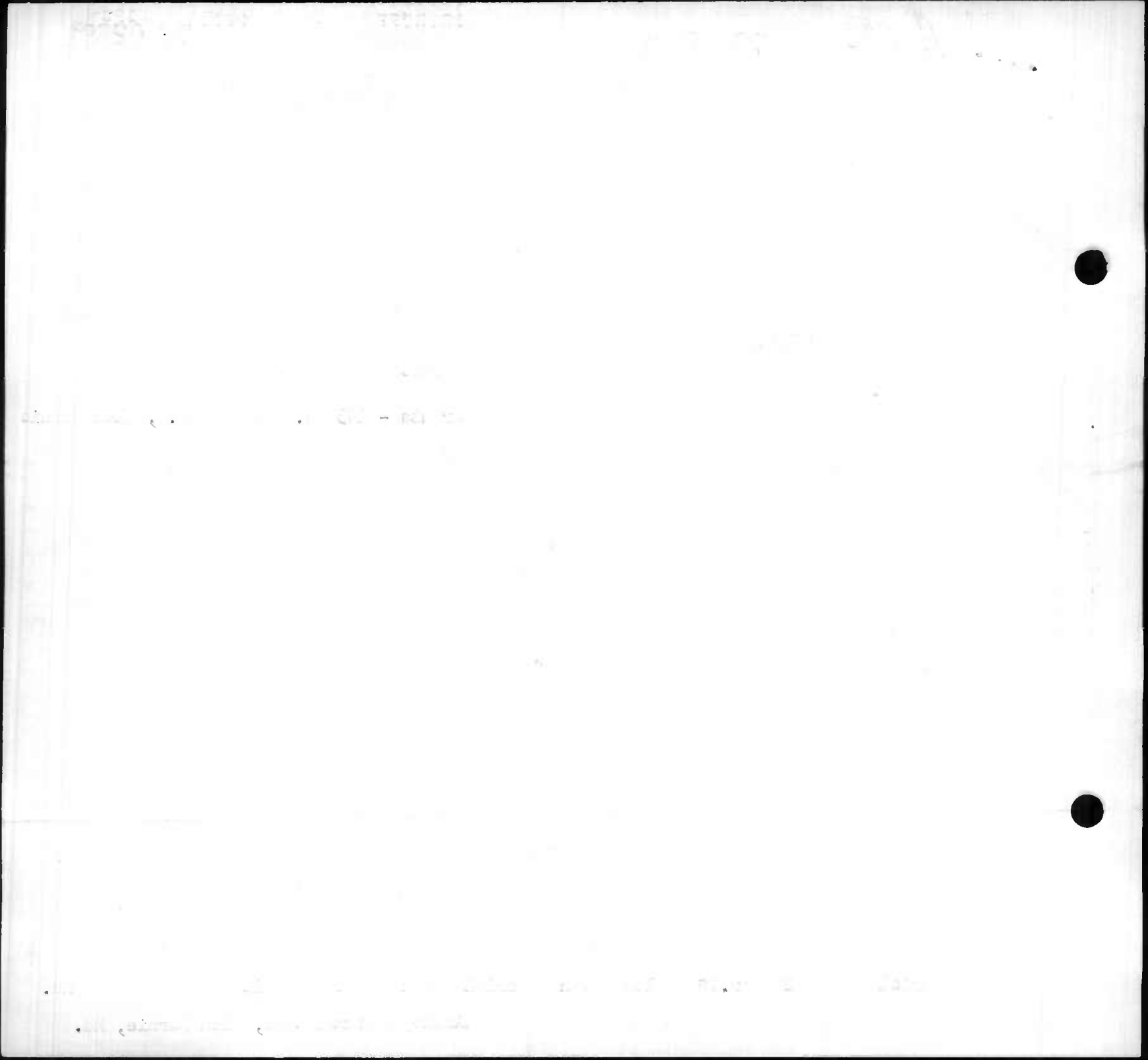
Department of the Interior

Wm. H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		SPS	
V-562 72 02891		PED. 72 02891	
BIRTH NO. 72-15890		REG. NO. 72 02891	
1. NAME OF DECEASED (Type or Print) <u>Timothy Van Airsdale</u>		2. DATE AND HOUR OF DEATH <u>3/20/72 2:45 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Maryland Hosp</u>		A. STATE <u>Foxleigh Dev't Center</u> B. COUNTY <u>5300</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Reisterstown</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday) <u>3</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr. Van Airsdale</u>		14. MOTHER'S MAIDEN NAME <u>EUNICE KINDRED</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>Parents - 103B N. CHARTER RD., Glen Burnie</u>	
18. <u>486X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Aspiration + Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pneumonia, Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Profound Mental Retardation</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> 19 <u>72</u> to <u>3/20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/20</u> 19 <u>72</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Roberta Lucas, MD</u>		23B. DATE SIGNED <u>3/20/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERTA LUCAS MD</u>		23D. ADDRESS <u>UNIV. HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>22 Mar. 72</u>	
24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Memorial Par k</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie AA Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

RECEIVED BY THE SECRETARY OF THE ARMY

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

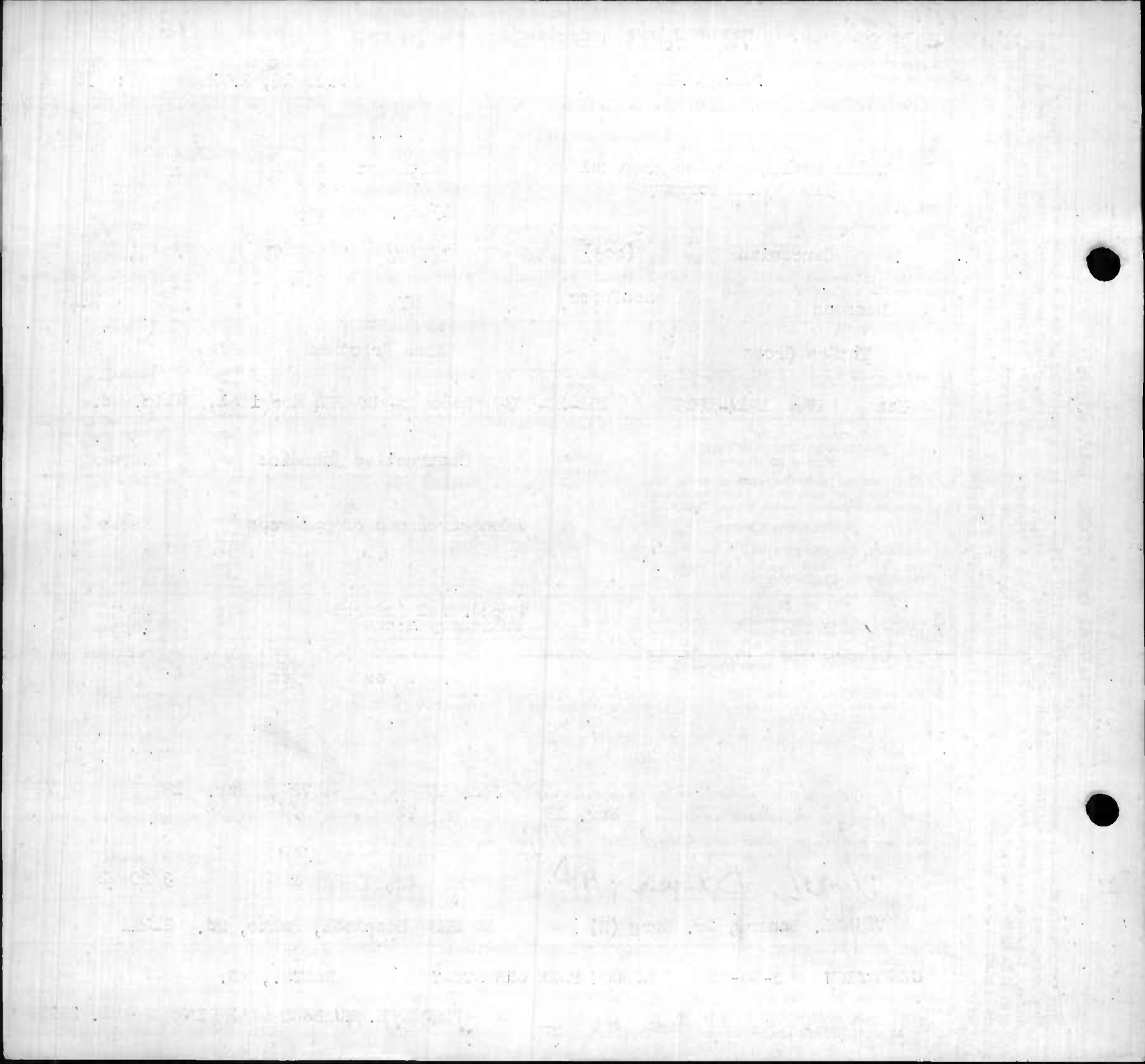
X

1917

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

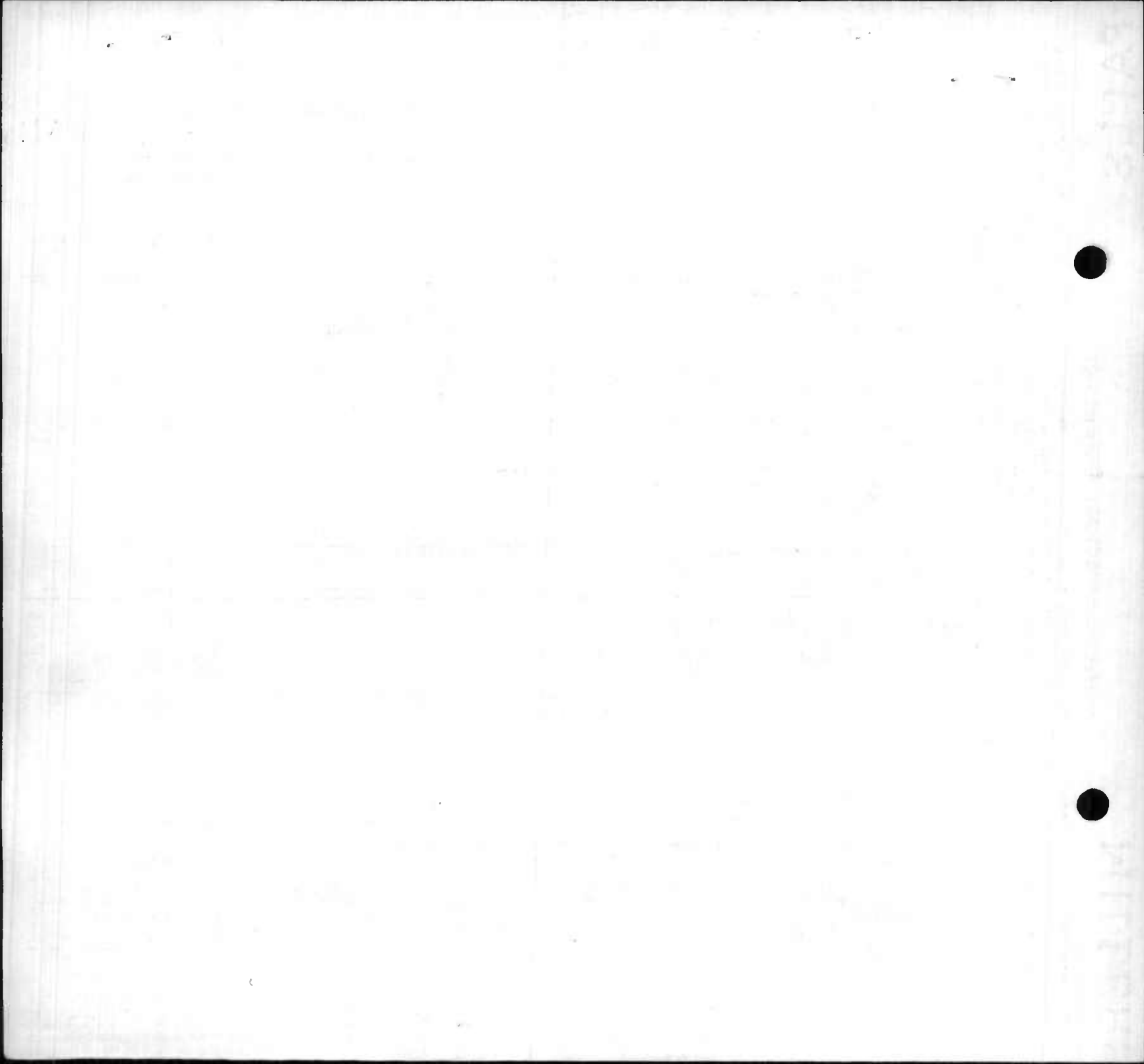
G-620		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02893	
BIRTH NO. 72 02893		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SAMUEL GROSS		2. DATE AND HOUR OF DEATH March 18, 1972 7: 35 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 301 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 131 N. Broadway			
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/97	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messman		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) NY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Gross		14. MOTHER'S MAIDEN NAME Anna Friedman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1914-1919		16. SOCIAL SECURITY NO. 101-10-0039		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Obstructive jaundice Adenocarcinoma of pancreas Myocardial infarct Pulmonary edema		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Weeks Days	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 19 19 72 to Mar. 18 19 72, that (I) (we) last saw the deceased alive on Mar. 18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. L. Bauer, M.D. DEGREE				23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Typed) V. L. Bauer, Sr. Surg (R) DEGREE				23D. ADDRESS US PHS Hospital, Balto, Md. 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 3-20-72		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CREMATORY	
24D. LOCATION BALTO., MD.		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

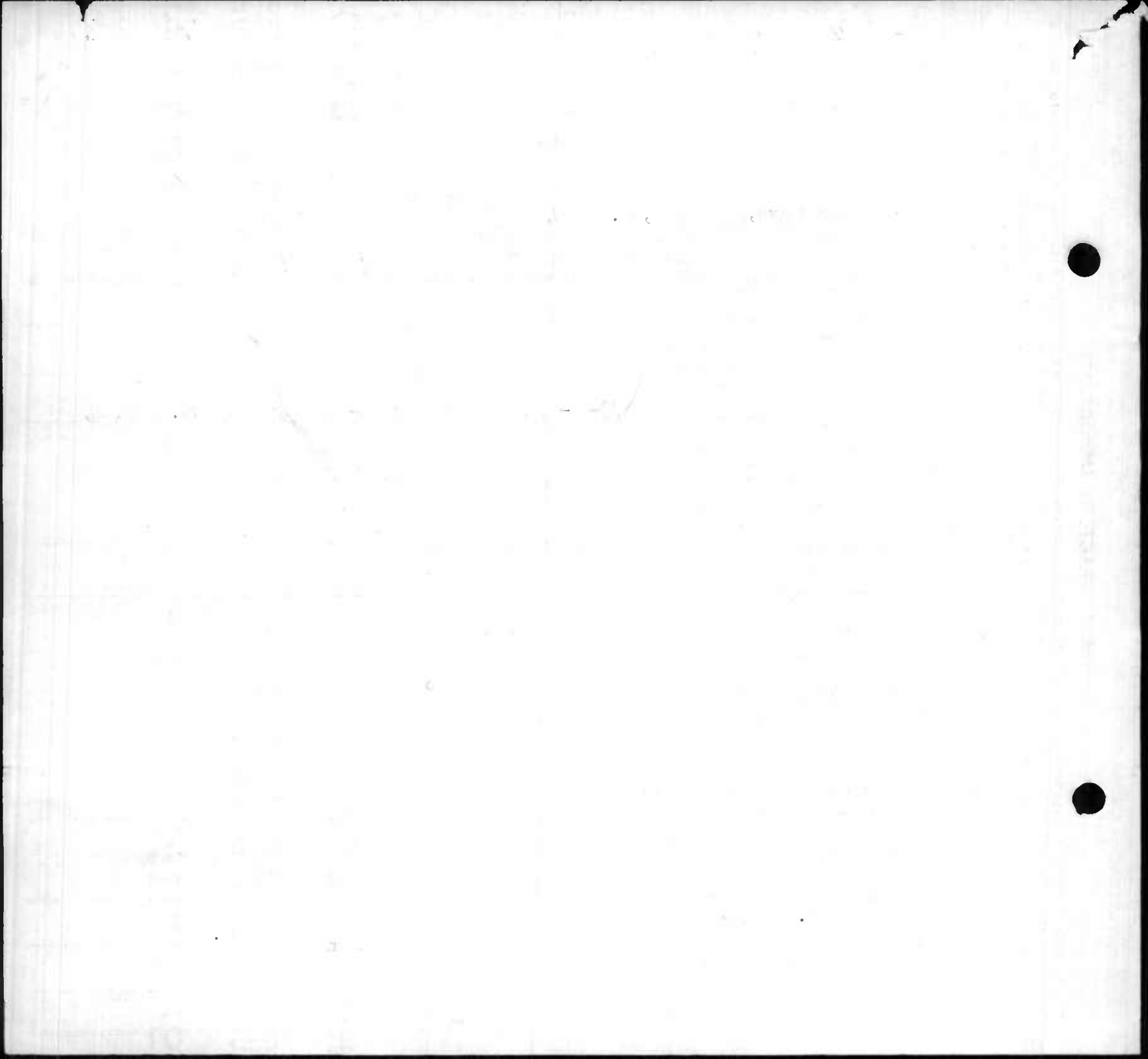
C-355		72 02894		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02894	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>TIMOTHY COTTMAN</u>				2. DATE AND HOUR OF DEATH <u>3/2/72</u> <u>4:45</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>5314 Lynview Ave</u> B. COUNTY <u>2831</u>			
						C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <u>Maryland 21215</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/58</u>		9. AGE (In years last birthday) <u>13</u>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harold Alcorn (father)</u>						14. MOTHER'S MAIDEN NAME <u>Gertrude</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. (INFORMANT ADDRESS <u>Records, Childrens Aid</u>			
18. <u>5-8-2-XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>DOA at Sinai Hospital</u> <u>Respiratory arrest</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>3-21-72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____									
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3-21-72</u> <u>4:45</u> <u>pm</u> <u>1972</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>3</u> <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>E. B. Golez, M.D.</u> DEGREE <u>M.D.</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/2/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. B. Golez, M.D.</u>						23D. ADDRESS <u>6203-13 Pimlico Rd., Balto. Md. 21209</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/24/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1972</u>		25B. NAME OF REGISTRAR <u>John E. Jones, M.D.</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		ADDRESS <u>1206 W North AVE</u>			



FUNERAL DIRECTOR: IMPORTANT

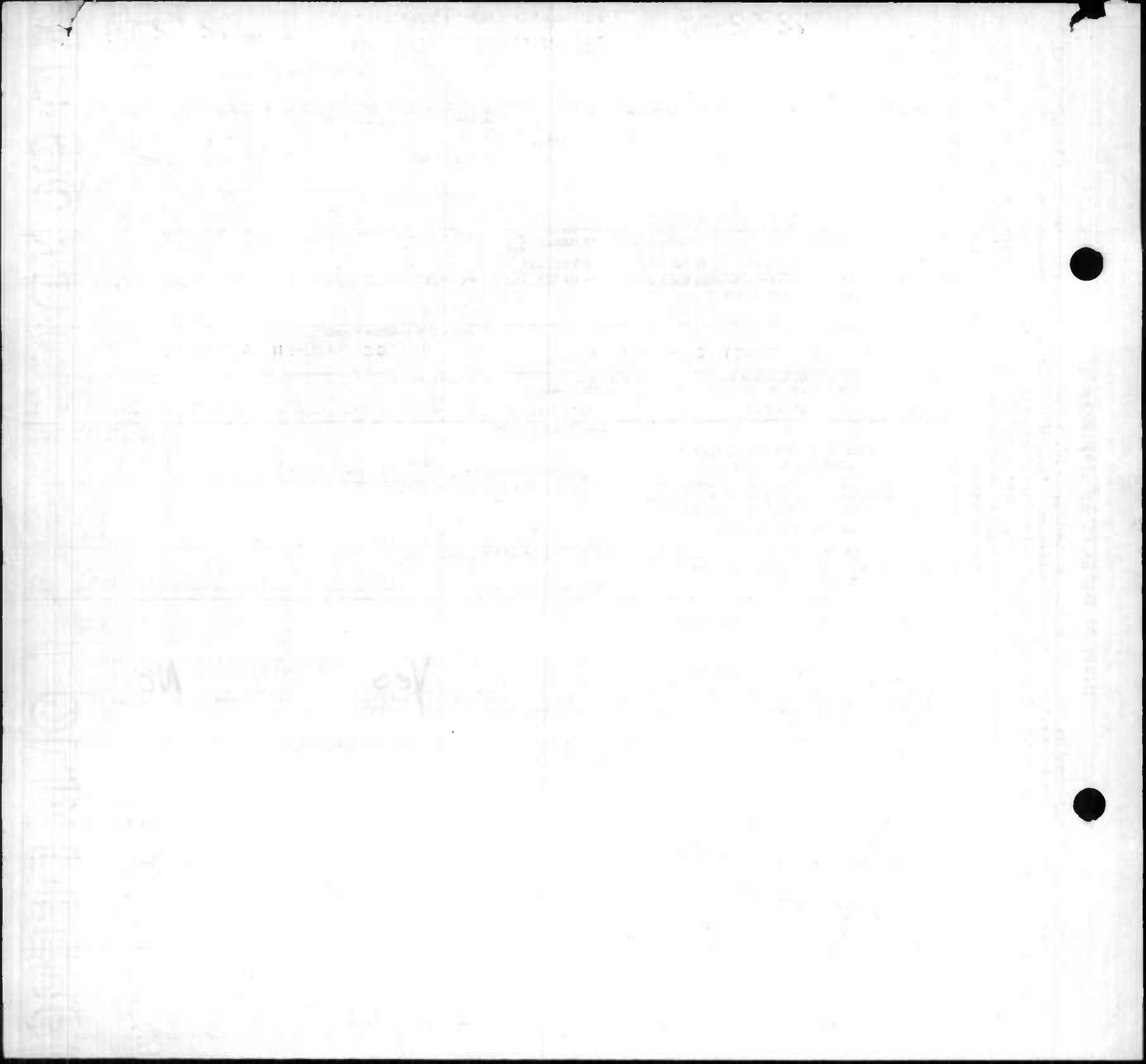
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02895		72 02895	
BIRTH NO. <u>C-326</u>		72 02895		72 02895	
1. NAME OF DECEASED (Type or Print) <u>CATHCART, GEORGE C.</u>		2. DATE AND HOUR OF DEATH <u>3-20-72</u> <u>7 45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Ave., Baltimore, Md. 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>702</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2519 ASHLAND AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1891</u>	9. AGE (in years last birthday) <u>81</u>	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>Johnson Catheart</u>		14. MOTHER'S MAIDEN NAME <u>Ella LAWSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>250-32-1963A</u>		17. INFORMANT <u>Records: BCH-4940 Eastern Ave. 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>593.21</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>DIFFUSE BLEEDING DIATHESIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>RENAL FAILURE</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>INTESTINAL OBSTRUCTION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> 19 <u>72</u> to <u>3-20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3-20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Sindelar</u>		23B. DATE SIGNED <u>3-20-72</u>		23C. PHYSICIAN'S NAME (Type) <u>W. SINDELAR</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-24-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. Calvary Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>A.A. County, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 23 1972</u>		25B. NAME OF REGISTRAR <u>George E. Kelly</u>	
25C. FUNERAL DIRECTOR <u>W. E. Elickson</u>		25D. ADDRESS <u>1244 Carolina</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02896	
S-630 72 02896		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Major E. Surrette Sr.		2. DATE AND HOUR OF DEATH 3/20/72 4:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/8/14 9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)		11. BIRTHPLACE (State or foreign country) N.C.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD SURRETTE HANNON		14. MOTHER'S MAIDEN NAME GRACE HANNON CHEATUM	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-05-7467	
17. INFORMANT		ADDRESS Willie May Surrette 1210 Brentwood Ave	
18. 2001 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aspiration pneumonia		2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Reticular cell carcinoma		1 yr	
19A. DATE OF OPERATION Dec. 1971 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Reticular cell carcinoma		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 1971 to March 20 1972 that (I) (we) last saw the deceased alive on 3/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Randolph Michael Hower M.D.		23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Type) Randolph Michael Hower M.D.		23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 23 1972		25B. NAME OF REGISTRAR John C. March	
25C. FUNERAL DIRECTOR John C. March		ADDRESS 928 E. North Ave	



W-623

72 02897

BALTIMORE CITY HEALTH DEPARTMENT

72 02897

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK WRIGHT III

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (If not in hospital or institution, give street
OR INSTITUTION ADDRESS OR LOCATION)

43 SOUTH BALTO. GENERAL HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 21, 1972

1:45 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

2506

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

12-29-41

10. AGE (In years
lost birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3400 Childs Court

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank J. Wright II

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Emma Powell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

220-36-8784

18. INFORMANT

ADDRESS

Patricia Wright 3400 Childs Court

19. 571.8

CAUSE OF DEATH

Fatty metamorphosis of liver

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Epilepsy (Old contusions of brain)

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/22/72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-24-72

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State)

Anne Arundel Cty., Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 23 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

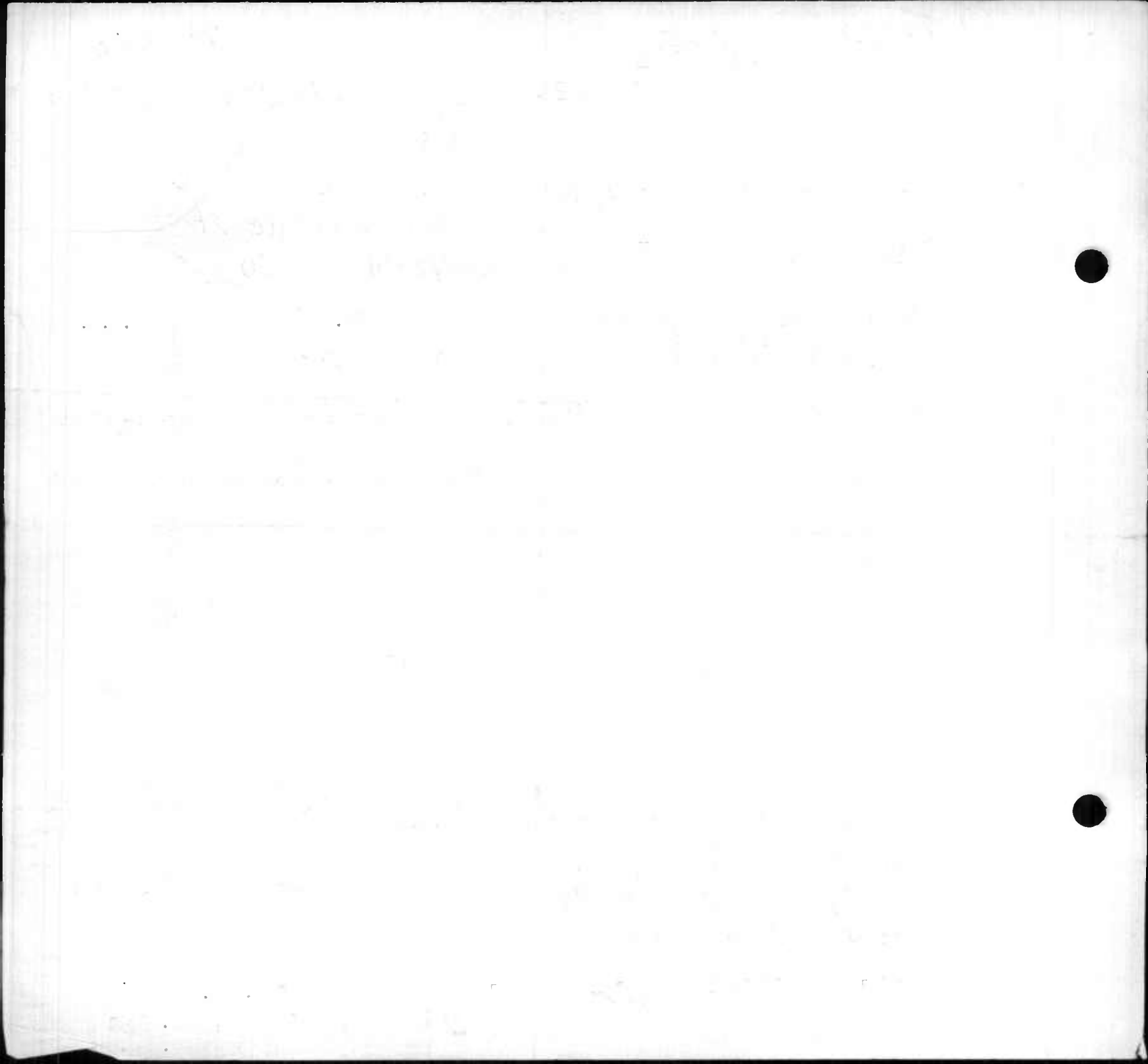
Wm C March

928 E North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-200		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02898	
BIRTH NO. 72 02898		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Elizabeth TAWES		2. DATE AND HOUR OF DEATH 3/20/72 5:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5 Good Samaritan Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 2634			
5. SEX F 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/29/11 9. AGE (In years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Edward Retowsky		14. MOTHER'S MAIDEN NAME Annie Allers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-12-6888		17. INFORMANT Robert Tawes (husband) ADDRESS same as above	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Disseminated Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disseminated Carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-4 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/13 19 72 to 3/20 19 72 that (I) (we) last saw the deceased alive on 3-20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry N. Hulter MD		23B. DATE SIGNED 3/20/72		23C. PHYSICIAN'S NAME (Type) HENRY N. HULTER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert A. Fisher MD		25C. FUNERAL DIRECTOR Schmunek Funeral Homes, Inc. ADDRESS 3331 Brehms Lane, Balto. Md.	



D-254

72 02899

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02899

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) ARTHUR B. DE CAMILLIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month March Day 21 , Year 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month March Day 21 , Year 1972 Hour 4:45 A.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/25/23		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 48		E. STREET AND NUMBER 3605 Hayward Avenue	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John DeCamillis		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II	
17. SOCIAL SECURITY NO. 229-22-0288		18. INFORMANT Adolph DeCamillia (brother) ADDRESS 1001 St. Paul	
19. E890X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Smoke inhalation CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Conflagration (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3510 Hayward Avenue		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 3-21-72	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found in burning house	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. DATE SIGNED March 21, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Richmond, Va.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.		ADDRESS 3331 Brehms Lane, Balto Md 21213	

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

1954

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

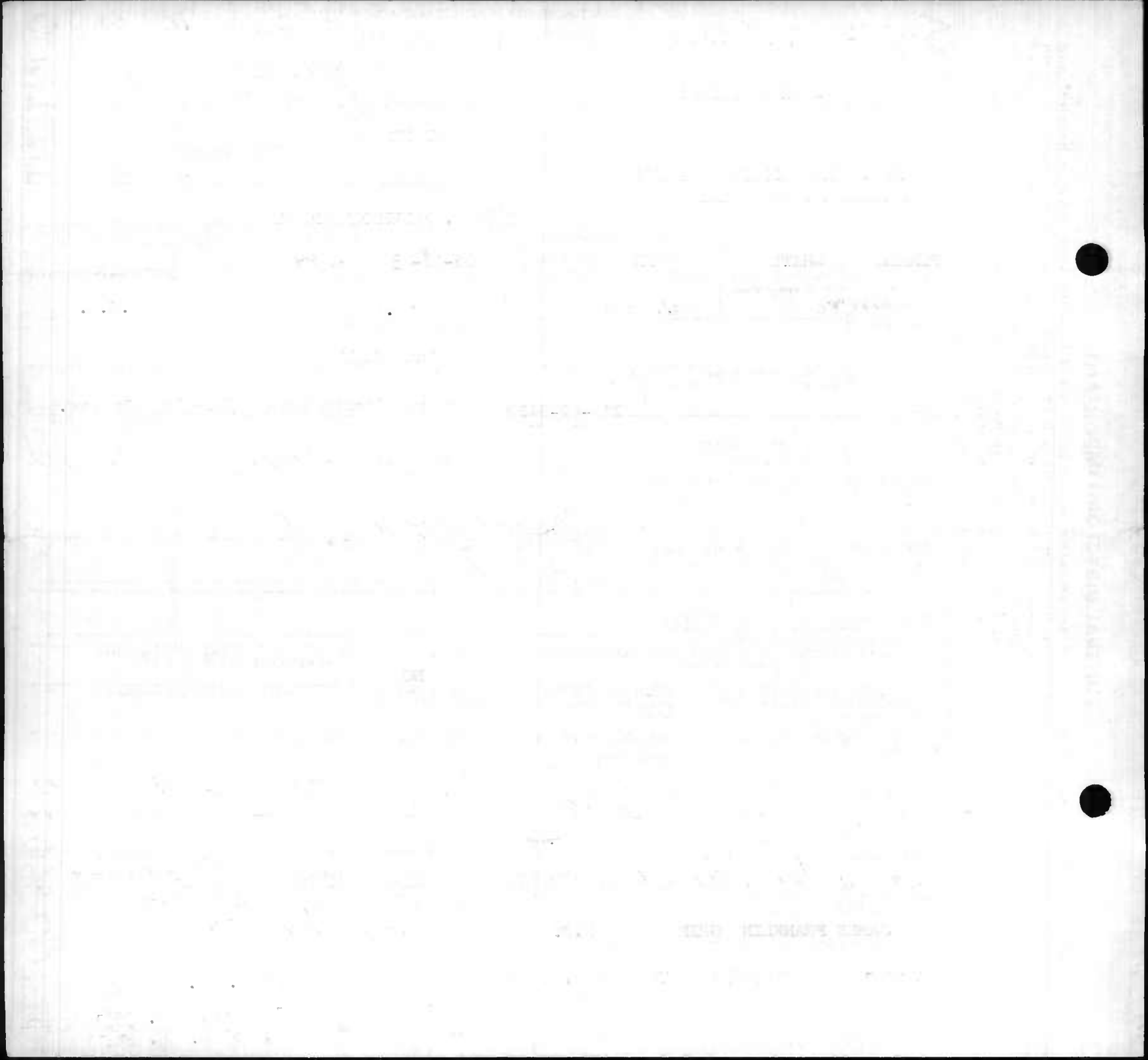
DATE 10-15-80 BY SP-6 PAK/ML

13

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

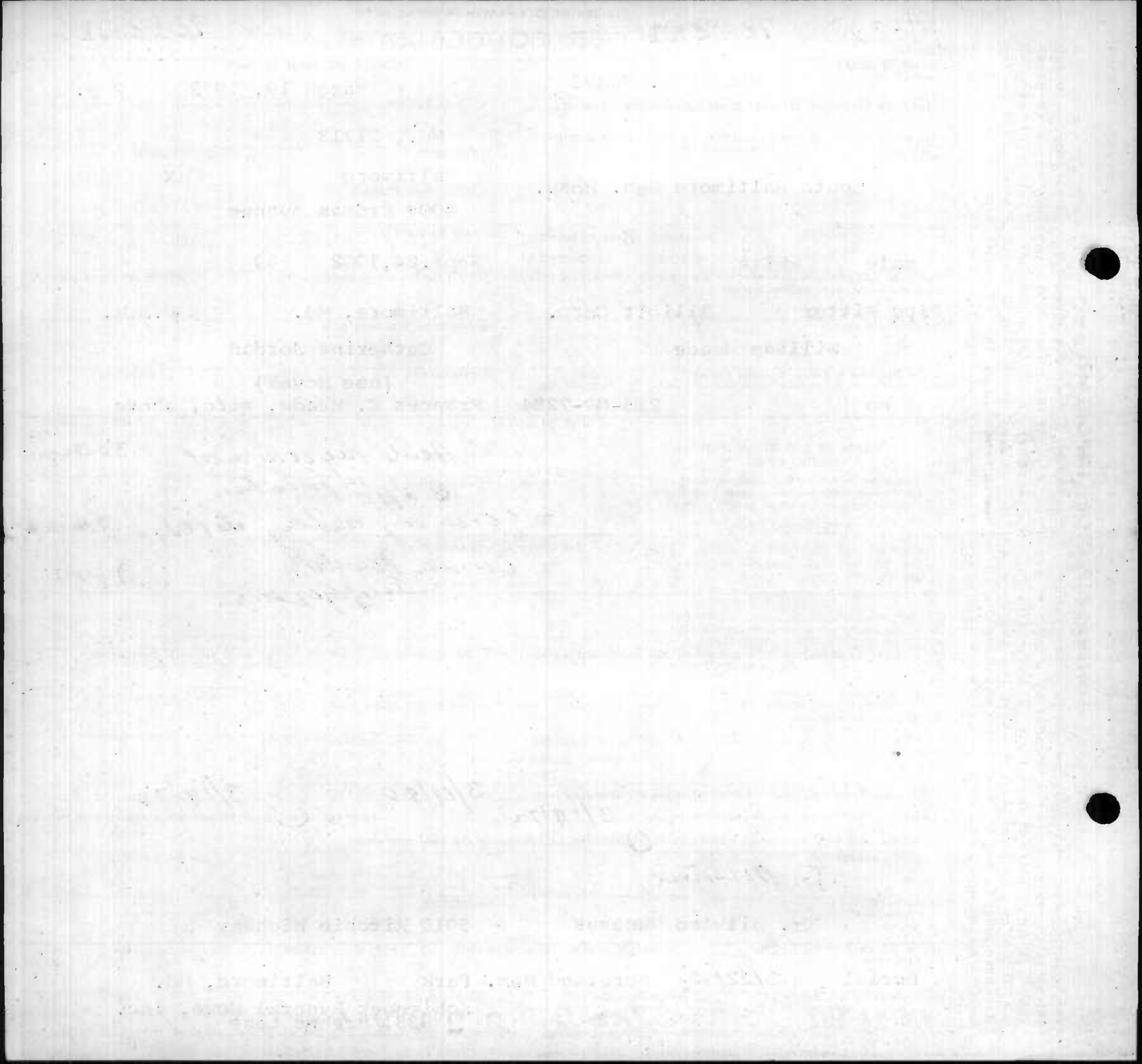
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-552		72 02900		72 02900	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LOUISE SIMMONS			3/18/72 10 ³⁵ P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			A. STATE MARYLAND B. COUNTY 702		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 2105 E. MONUMENT STREET					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-23-83	9. AGE (In years last birthday) 89	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Regina Pfaff		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-42-5430		17. INFORMANT Bernard Simmons (son)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF: (B) Massive Anterior MI DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16 19 72 to 3/18 19 72 that (I) (we) last saw the deceased alive on 3/18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Franklin Grim M.D.				23B. DATE SIGNED 3/18/72	
23C. PHYSICIAN'S NAME (Type) JAMES FRANKLIN GRIM		23D. ADDRESS 1528 McElderry St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/22/72		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Balto. Md.		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert C. Taylor M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

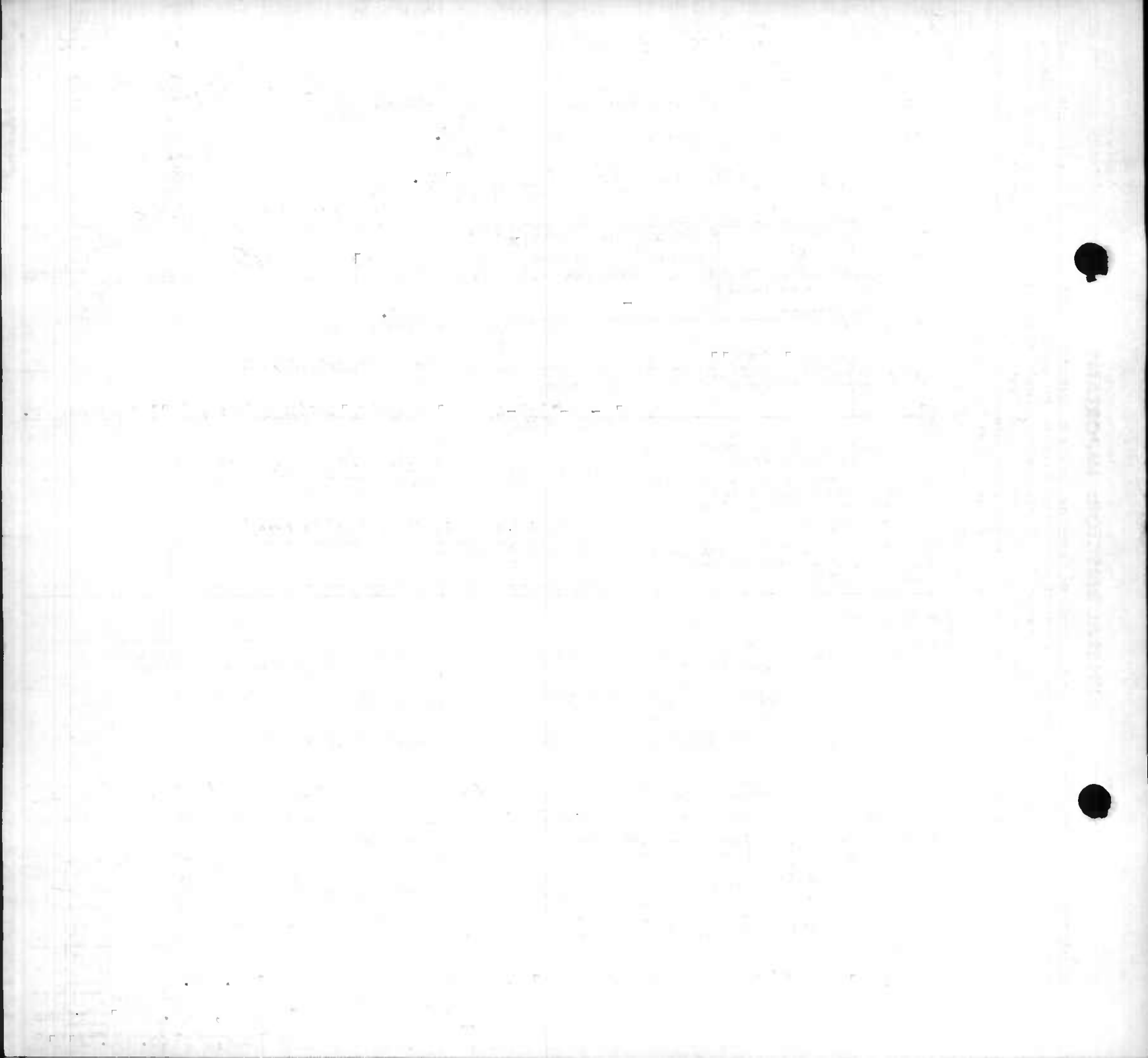
M-300 72 02901				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02901	
1. NAME OF DECEASED (Type or Print)				WALTER M. MEADE		2. DATE AND HOUR OF DEATH March 19, 1972 2 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Gen. Hosp.				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md., 21213		2643	
5. SEX male				6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 24, 1902 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter				10B. KIND OF BUSINESS OR INDUSTRY Elliott Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Meade				14. MOTHER'S MAIDEN NAME Catherine Jordan		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 215-09-7284				17. INFORMANT (nee Novak) Frances C. Meade, wife, above				ADDRESS	
18. 4/10.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: - Acute Myocardial Infarction - Coronary artery disease - Chronic Bronchitis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 3 months 3 yrs					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/19/70 19 to 3/19/72 19, that (I) (we) lost saw the deceased olive on 3/19/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE S. Munoz				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) Dr. Silvino Muneses	
23D. ADDRESS 5010 Ritchie Highway				24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 3/22/72				24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972				25B. NAME OF REGISTRAR Schimunek Funeral Home, Inc.				25C. FUNERAL DIRECTOR 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02902</u>
BIRTH NO. <u>7-424</u>		72 02902		CERTIFICATE OF DEATH
1. NAME OF DECEASED <small>(Type or Print)</small> <u>FLEISHELL NELLIE</u>		2. DATE AND HOUR OF DEATH <u>MARCH 20, 1972 9:50 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2734</u> 5. CITY OR TOWN <u>Balto.</u> 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER <u>6116 BELAIR Rd. 21206</u>		
8. SEX <u>F</u>	9. RACE <u>W</u>	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH <u>9-20-1881</u>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		13. KIND OF BUSINESS OR INDUSTRY <u>-</u>		
14. FATHER'S NAME <u>John Fleishell</u>		15. MOTHER'S MAIDEN NAME <u>Suzanna Hutton</u>		
16. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <u>no</u>		17. SOCIAL SECURITY NO. <u>215-05-1353</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> <u>560.91</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>INTESTINAL OBSTRUCTION</u> <u>SEVERE DEHYDRATION</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) SEVERE DEHYDRATION DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20. DATE OF OPERATION <u>0</u>		21. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO</u>		
25. TIME OF INJURY (Month) (Day) (Year) (Hour) <small>(APPROX.)</small>		26. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
27. HOW DID INJURY OCCUR?				
28. I certify that (I) (this hospital) attended the deceased from <u>March 20</u> 19 <u>72</u> to <u>March 20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>March 20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
29. SIGNATURE <u>Dr. H. F. Scheel</u>		30. DATE SIGNED <u>MARCH 20 - 72</u>		
31. PHYSICIAN'S NAME (Type) <u>H. F. SCHEEL M.D.</u>		32. ADDRESS <u>UNION MEMORIAL HOSP.</u>		
33. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		34. DATE <u>3/23/72</u>		
35. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		36. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
37. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		38. NAME OF REGISTRAR <u>Schumacher</u>		
39. FUNERAL DIRECTOR <u>Schumacher</u>		40. ADDRESS <u>Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

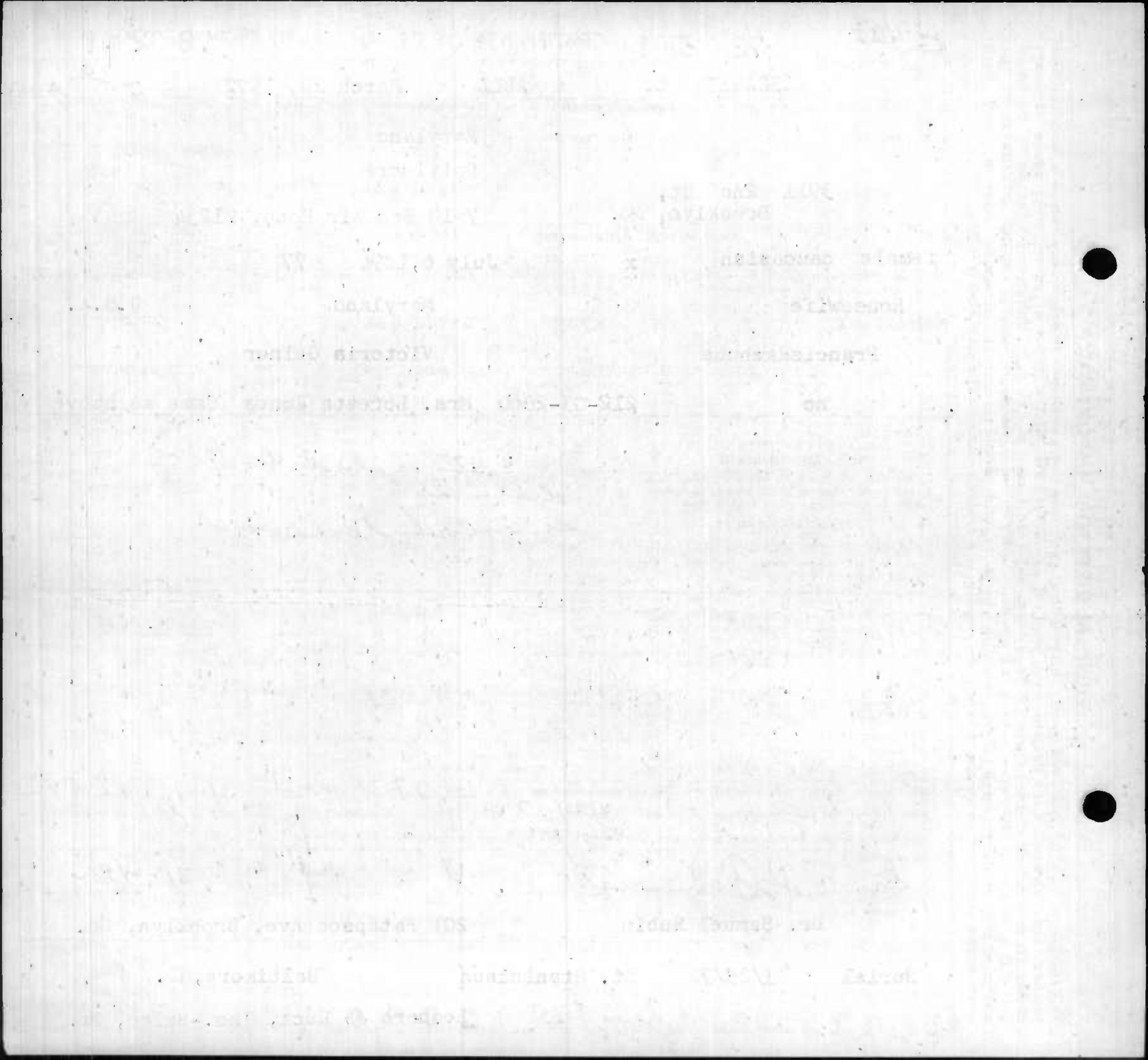
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02903
B-523 72 02903		CERTIFICATE OF DEATH		
BIRTH NO. 1. NAME OF DECEASED (Type or Print) WILLIAM HARRELL BANKSTON		2. DATE AND HOUR OF DEATH March 22, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5217 Apt E. Frankford Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2741 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5011 Eugene Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 12, 1907	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Georgia
13. FATHER'S NAME Benjamin Bankston		14. MOTHER'S MAIDEN NAME Julia Harrell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 578-05-7666	17. INFORMANT ADDRESS Mrs. Anna B. McLevitt Same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Jan 19 61 to March 22 19 72, that (I) (we) last saw the deceased alive on 2/29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Robert G. Levy</i>		23B. DATE SIGNED 3/22/72		23C. PHYSICIAN'S NAME (Type) Dr. Robert G. Levy
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/72		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Leonard J. Buck		25C. FUNERAL DIRECTOR ADDRESS Buck Inc., Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

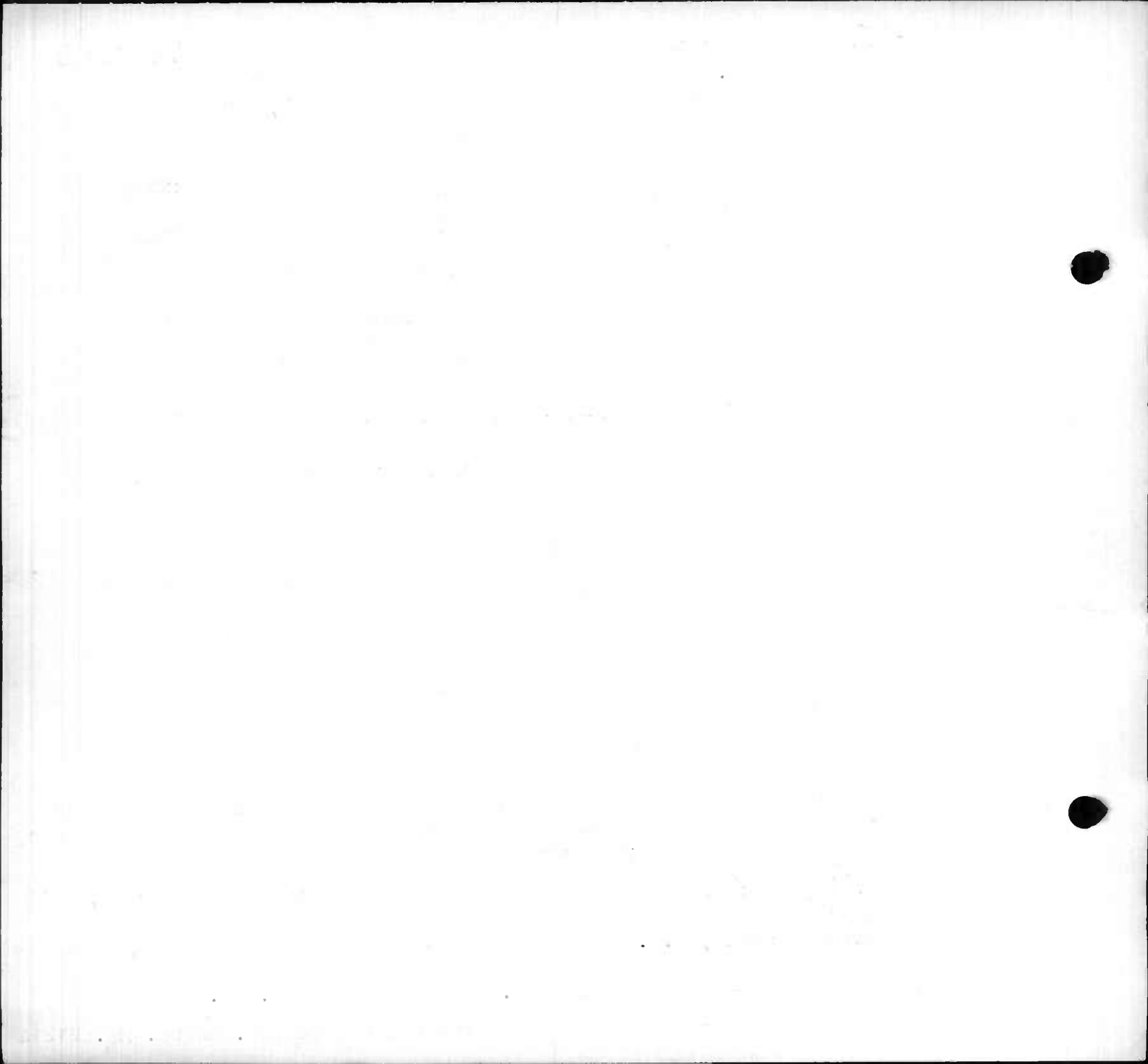
A-400		72 02904		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02904	
1. NAME OF DECEASED (Type or Print) ELIZABETH C. AULL				2. DATE AND HOUR OF DEATH March 22, 1972 5:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 3911 2nd St, Brooklyn, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland BALTO 5300 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7910 Bon Air Road, 21234			
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1894 77	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Francis Rachuba				14. MOTHER'S MAIDEN NAME Victoria Gelner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-03-2060		17. INFORMANT ADDRESS Mrs. Loretta Jones Same as above			
18. 4/12/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0				CAUSE OF DEATH (A) IMMEDIATE CAUSE arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic (C) DUE TO, OR AS A CONSEQUENCE OF: 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 15 1972 to 3/21 1972 that (I) (we) last saw the deceased alive on 3/21/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel Rubin 301				23B. DATE SIGNED 3/24/72		23C. PHYSICIAN'S NAME (Type) Dr. Samuel Rubin	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/25/72		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Leonard J. Ruck		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-Balto, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02905</u>	
W-656				72 02905	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HILDA WOERNER			MARCH 21 1972 11:40 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 45 The Good Samaritan Hospital			A. STATE MARYLAND		
			B. COUNTY 2735		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3209 WOODRING AVENUE		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 22 24	9. AGE (In years lost birthday) 47	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FREDERICK WOERNER			14. MOTHER'S MAIDEN NAME LILLIAN Pritchett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-22-4302	17. INFORMANT Mr Milton Woerner 8143 Pleasant Plains		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYASTHENIA LIKE SYNDROME 2 MONTHS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 15 1972 to March 21 1972 that (I) (we) last saw the deceased alive on March 21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE Alfred Munzer			23B. DATE SIGNED March 21, 1972		23C. PHYSICIAN'S NAME (Type) Alfred Munzer, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-24-72		24C. NAME of CEMETERY or CREMATORY Baltimore Cem.
24D. LOCATION Balto. Md.			25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		
25B. NAME OF REGISTRAR Leonard J Ruck Inc.			25C. FUNERAL DIRECTOR Balto. Md. 21214		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-355 72 02906				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02906	
1. NAME OF DECEASED (Type or Print) GOODMAN, JAMES T				2. DATE AND HOUR OF DEATH March 20 1972 4:00 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2735			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/0089	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker		10B. KIND OF BUSINESS OR INDUSTRY retired		9. AGE (In years last birthday) 82		11. BIRTHPLACE (State or foreign country) Ashland, Ky.	
13. FATHER'S NAME Buck Goodman				14. MOTHER'S MAIDEN NAME Mollie xxxxxx Senners			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/7/18 - 12/19/18		16. SOCIAL SECURITY NO. 403-09-4326		17. INFORMANT VA Hospital Records		ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				(A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: Coronary arteriosclerotic, severe		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
19A. DATE OF OPERATION 2/25 & 3/4/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED constructing lesion of colon		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from February 14th 1972 to March 20th 1972 , that (1) (we) last saw the deceased alive on March 20th 1972 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (d/d/f) view the body after death.							
23A. SIGNATURE Donald H. Hooker DEGREE				23B. DATE SIGNED 3/21/72		23C. PHYSICIAN'S NAME (Type) DONALD H. HOOKER, M.D. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/72		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Leonard J. Ruck		25C. FUNERAL DIRECTOR ADDRESS Inc. Baltimore, Md			

3015

XXXXXX XXXXXX

111

FIELD, BRITAIN

5/25/52

1011

RECEIVED FROM THE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 02907 CERTIFICATE OF DEATH									
BIRTH NO. 72 02907					REG. NO. 72 02907				
1. NAME OF DECEASED (Type or Print) Helen L De Vane <i>HELEN DEVANE</i>					2. DATE AND HOUR OF DEATH 3-21-72 7:35 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2702 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3012 GRINDON AVE - BALTO 21214				
5. SEX Female		6. RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-03		9. AGE (In years lost birthday) 68 XX	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) XXXXXXXXXX New York			12. CITIZEN OF WHAT COUNTRY? AMERICAN USA		
13. FATHER'S NAME Anthony Petone					14. MOTHER'S MAIDEN NAME Anna Kassell				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 218-46-1201		17. INFORMANT EDWARD A. NOPKINS ADDRESS 438 STENNERS		
18. 410.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____									
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-20 19 72 to 3-21 19 72 , that (I) (we) lost saw the deceased alive on 3-21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Juan M. Calderon DEGREE							Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-21-72
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D. DEGREE							23D. ADDRESS UMH		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-24-72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972					25B. NAME OF REGISTRAR Leonard J. Buck		25C. FUNERAL DIRECTOR Leonard J. Buck Inc. Balto. Md. 21214		

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

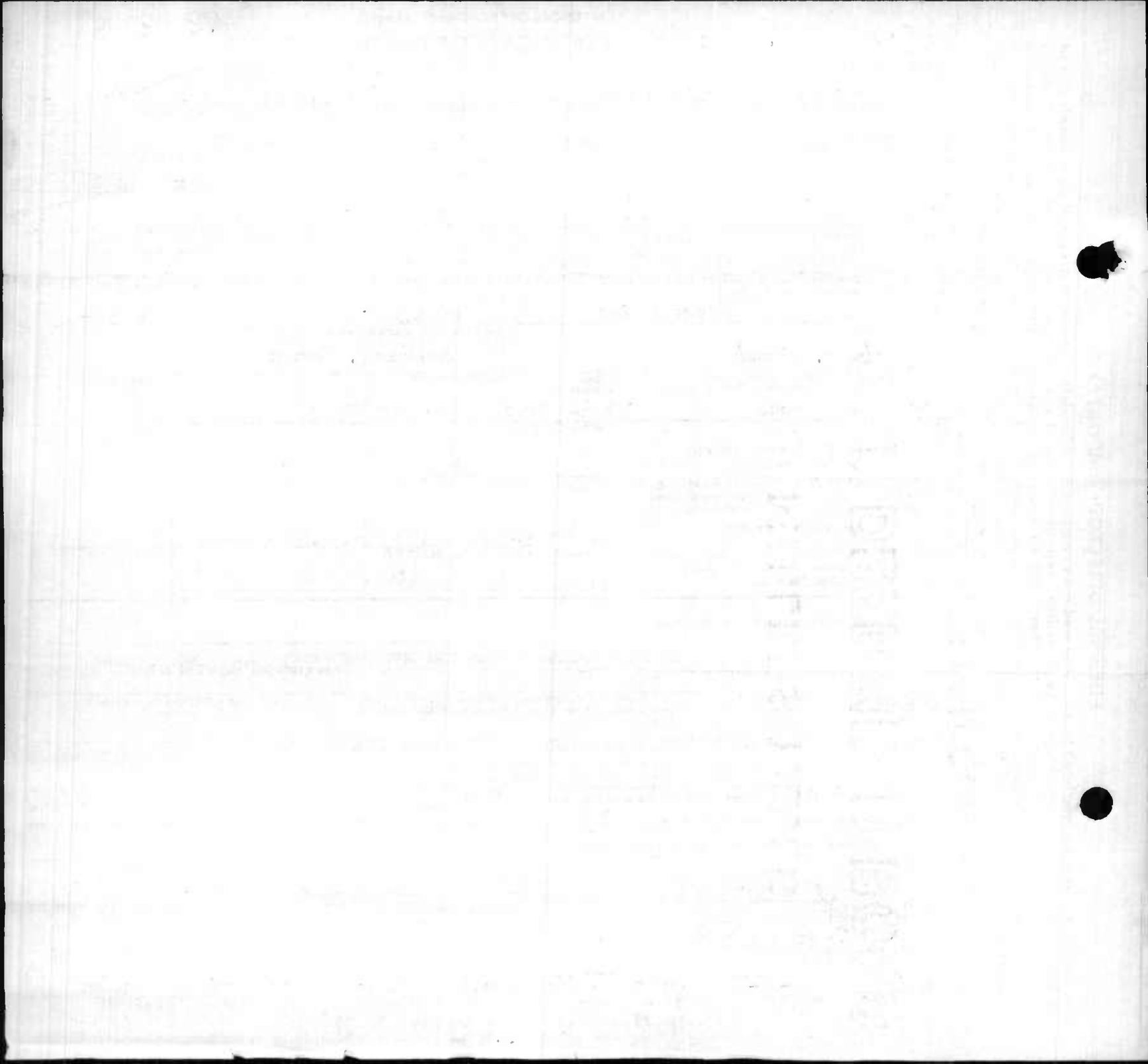
XXXXXX

XXXXXX

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

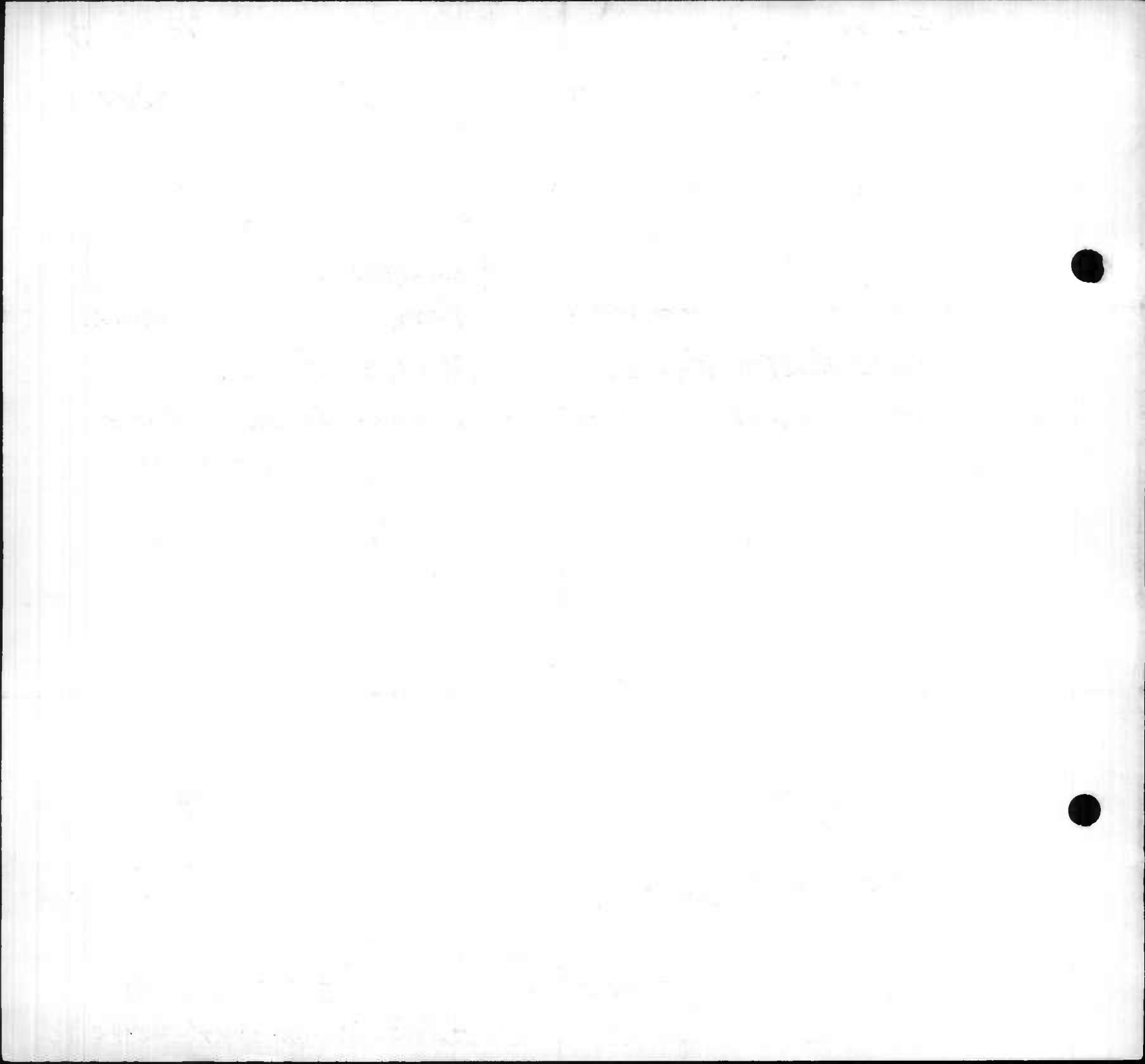
BALTIMORE CITY HEALTH DEPARTMENT or Mch REG. NO. 72 02908		72 02908	
BIRTH NO. K-540		72 02908	
1. NAME OF DECEASED (Type or Print) Louis C. Kimmel		2. DATE AND HOUR OF DEATH March 21 1972 9⁴⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2 Baltimore C. CITY OR TOWN Timonium D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 9 Evans Ave Timonium 21093	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-47
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail man		10B. KIND OF BUSINESS OR INDUSTRY Post office	9. AGE (In years last birthday) 24
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Kimmel		14. MOTHER'S MAIDEN NAME Dorothea E. Keener	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no none		16. SOCIAL SECURITY NO. 213-46-2399	17. INFORMANT Chart
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: General Cerebral (B) DUE TO, OR AS A CONSEQUENCE OF: Melasma's to Seros, Lung (C) Ecchym Hemorrh	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/21 19 72 to 3/21 19 72 that (1) (we) lost saw the deceased alive on 3/21 19 72 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George C. Samaras MD		23B. DATE SIGNED 3/21/72	23C. PHYSICIAN'S NAME (Type) GEORGE C. SAMARAS MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-72	24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens
24D. LOCATION (City, town, or county) Cockeysville Maryland		(State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Jones	25C. FUNERAL DIRECTOR John J. Jones



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

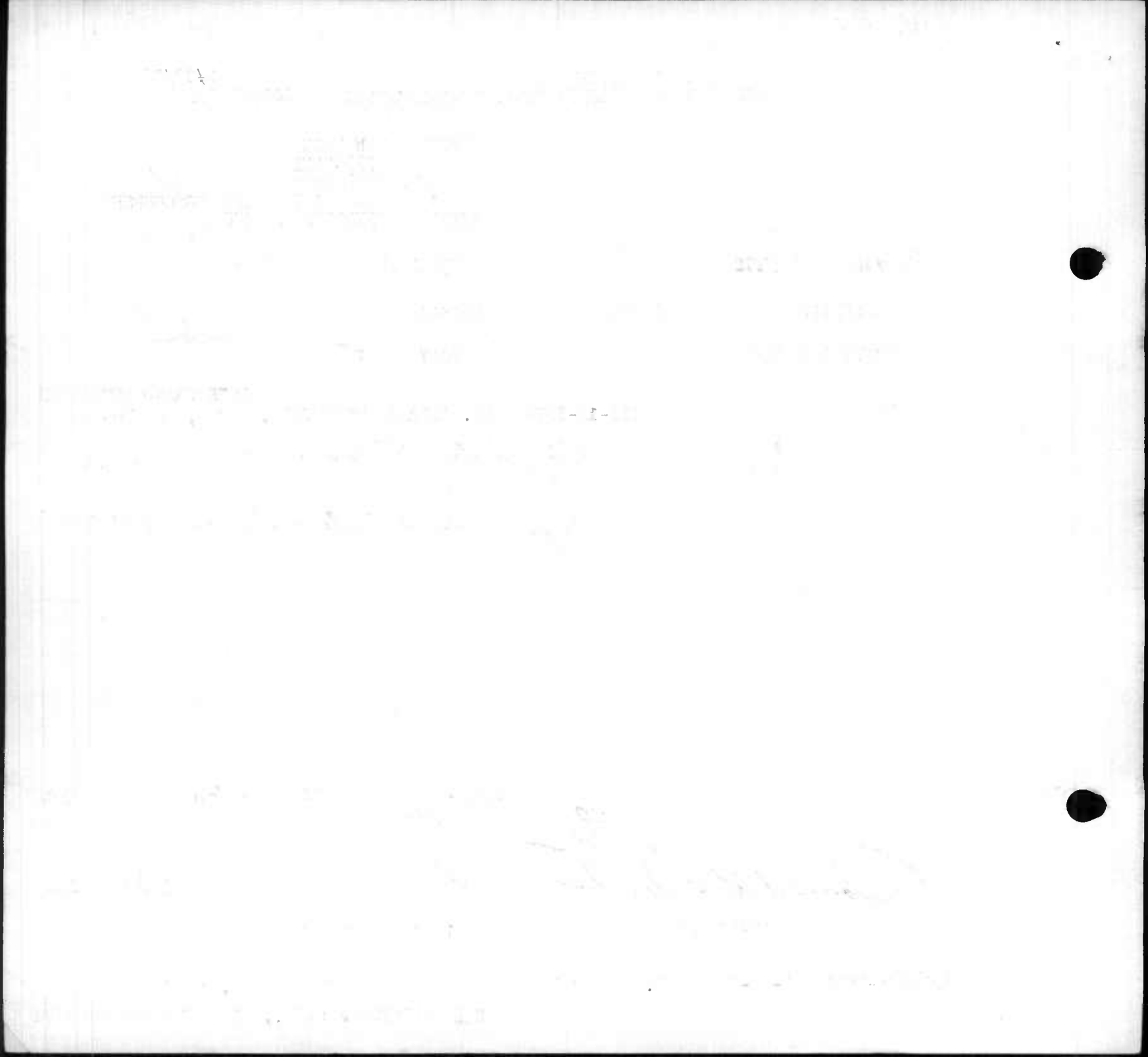
BALTIMORE CITY HEALTH DEPARTMENT		72 02909		REG. NO. 72 02909	
E-236		72 02909		72 02909	
1. NAME OF DECEASED (Type or Print) <u>Charles W. Easter</u>		2. DATE AND HOUR OF DEATH <u>3/19/72</u> <u>1244 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1207</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2203 Huntington Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 28, 1911</u>	9. AGE (In years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>construction</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>IRON WORK</u>		11. BIRTHPLACE (State or foreign country) <u>TENN.</u>	
13. FATHER'S NAME <u>DAVID HOUSTON EASTER</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE FISHER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>408-05-3056</u>		17. INFORMANT <u>MRS. YOLANDA EASTER</u>	
18. <u>162.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3/16/1972</u> to <u>3/19/1972</u> that (1) (we) last saw the deceased alive on <u>3/19/1972</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William Ross Davidson Jr. M.D.</u>		23B. DATE SIGNED <u>March 19, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>William Ross Davidson Jr. M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-23-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>NEW CATHEDRAL</u>	
24D. LOCATION <u>BALTIMORE, MD.</u>		25. NAME OF REGISTRAR <u>J. Walter C. ...</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. FUNERAL DIRECTOR <u>J. Walter C. ...</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02910	
1. NAME OF DECEASED (Type or Print) Clara HALPER MYERSTEIN				2. DATE AND HOUR OF DEATH 3/20/72 12:10 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Maryland General Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE NEW YORK B. COUNTY BRONX			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hosp.				C. CITY OR TOWN BRONX D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH XXXXXX		9. AGE (In years last birthday) 88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME MAURICE WEGMAN				14. MOTHER'S MAIDEN NAME MARY ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 111-12-3370		17. INFORMANT MR. ABRAHAM MYERSTEIN, BRONX, NEW YORK	
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration Pneumonia (B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks > 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/24 19 72 to 3/20 19 72 that (I) (we) last saw the deceased alive on 3/20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald H. Dembo				23B. DATE SIGNED 3/20/72		23C. ADDRESS 827 LINDEN AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		24B. DATE 3-23-72		24C. NAME OF CEMETERY or CREMATORY MT. PLEASANT		24D. LOCATION (City, town, or county) (State) PLEASANTVILLE, NEW YORK	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR SOI LEVINSON & BROS.		25C. FUNERAL DIRECTOR ADDRESS 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02911</u>
BIRTH NO. <u>K-321</u> 1. NAME OF DECEASED (Type or Print) <u>RACHEL KATZOFF</u>		2. DATE AND HOUR OF DEATH <u>MARCH 22, 1972</u> <u>12¹⁵</u> <u>A.M.</u> 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>IMPERIAL APTS., APT. 503</u> <u>3601 CLARKS LANE</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3601 CLARKS LANE, APT. 503</u>		5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/ 1875</u> 9. AGE (In years last birthday) <u>96</u> 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> 11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>SAMUEL SNYDER</u> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>217-54-9819</u>		17. INFORMANT <u>MISS FANNIE KATZOFF, 3601 CLARKS LANE, APT. 503</u> ADDRESS <u>MISS FANNIE KATZOFF, 3601 CLARKS LANE, APT. 503</u>		
18. CAUSE OF DEATH <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>ASC V disease - failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Arteriosclerosis -</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>3/13</u> 19 <u>72</u> to <u>3/22/72</u> 19 that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Nathan E. Needle</u> 23B. DATE SIGNED <u>3/22/72</u> 23C. PHYSICIAN'S NAME (Type) <u>NATHAN E. NEEDLE</u> 23D. ADDRESS <u>606 PARK HEIGHTS AVENUE</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>3-22-72</u> 24C. NAME of CEMETERY or CREMATORY <u>RIGA KURLANDER VEREIN</u> 24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u> 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u> 25B. NAME OF REGISTRAR <u>SOL DEVINSON</u> 25C. FUNERAL DIRECTOR <u>SOL DEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>				

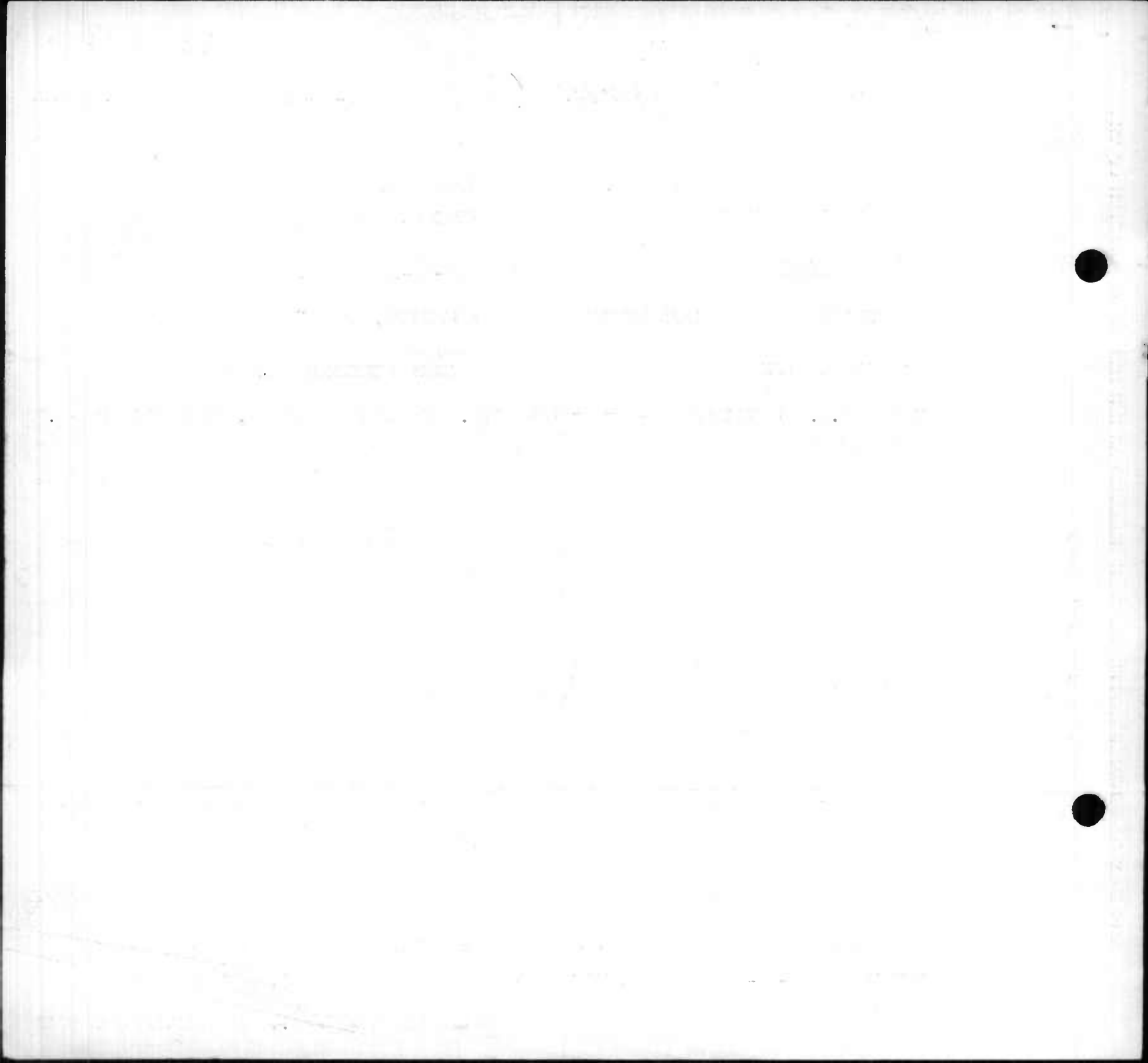
THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637
TEL. 733-4331
1968

FUNERAL DIRECTOR: IMPORTANT

MEDICAL EXAMINER'S OFFICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02912	
BIRTH NO. 4-655				72 02912			
1. NAME OF DECEASED (Type or Print) <u>HERMAN, BENJAMIN (Ben)</u>				2. DATE AND HOUR OF DEATH 03-19-72 4:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>5300</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09-16-24</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		9. AGE (in years last birthday) <u>47</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>MORRIS HERMAN</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W. II MARINES</u>				16. SOCIAL SECURITY NO. <u>215-16-7794</u>		17. INFORMANT <u>MRS. BEVERLY JUNE HERMAN, 6703 CHELWOOD RD. #9</u>	
18. <u>4/2-3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ventricular failure</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery disease</u> 1 year (B) _____ (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>3 3/19/72</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Coronary artery disease</u>			
20A. AUTOPSY? (Yes or No) <u>Yes</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>March 16 1972</u>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>March 16</u> 19 <u>72</u> to <u>March 19</u> 19 <u>72</u> that <u>(H)</u> (we) last saw the deceased alive on <u>March 19</u> 19 <u>72</u> and that in <u>(our)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Philip Rosenbloom, MD</u>				23B. DATE SIGNED <u>March 19, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>PHILIP ROSENBLOOM M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>3-21-72</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>				25B. NAME OF REGISTRAR <u>SOL LEVINSON & BROS.</u>		25C. FUNERAL DIRECTOR'S ADDRESS <u>6010 REISTERSTOWN ROAD</u>	



72 02913
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02913

REG. NO.

BIRTH NO.

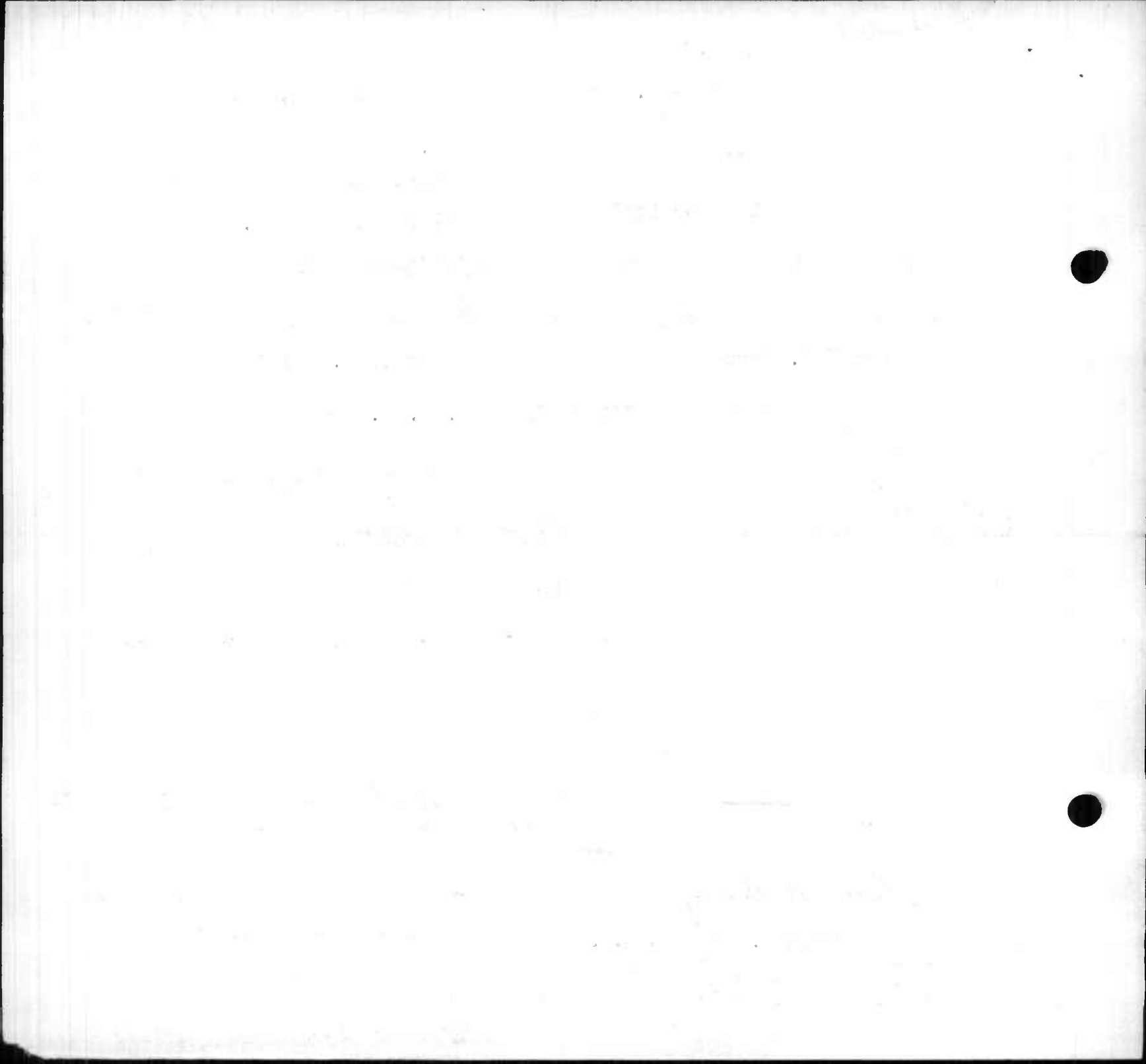
1. NAME OF DECEASED (Type or Print) THOMAS ROBERTSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 20 1972 1:35 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1307	
9. DATE OF BIRTH Jan 10 1934		10. AGE (In years last birthday) 38	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John V. B. Robertson		14. MOTHER'S MAIDEN NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		14B. KIND OF BUSINESS OR INDUSTRY Gasolene Service Station Hazel Ball	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219 28 2215	
18. INFORMANT Lawrence E. Knott Sr.		ADDRESS same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-20-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 23 Mar 72	
24C. NAME OF CEMETERY or CREMATORY Crest Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Howard Co, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert S. Fisher, M.D.	
25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore Md		ADDRESS 3-20-72	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

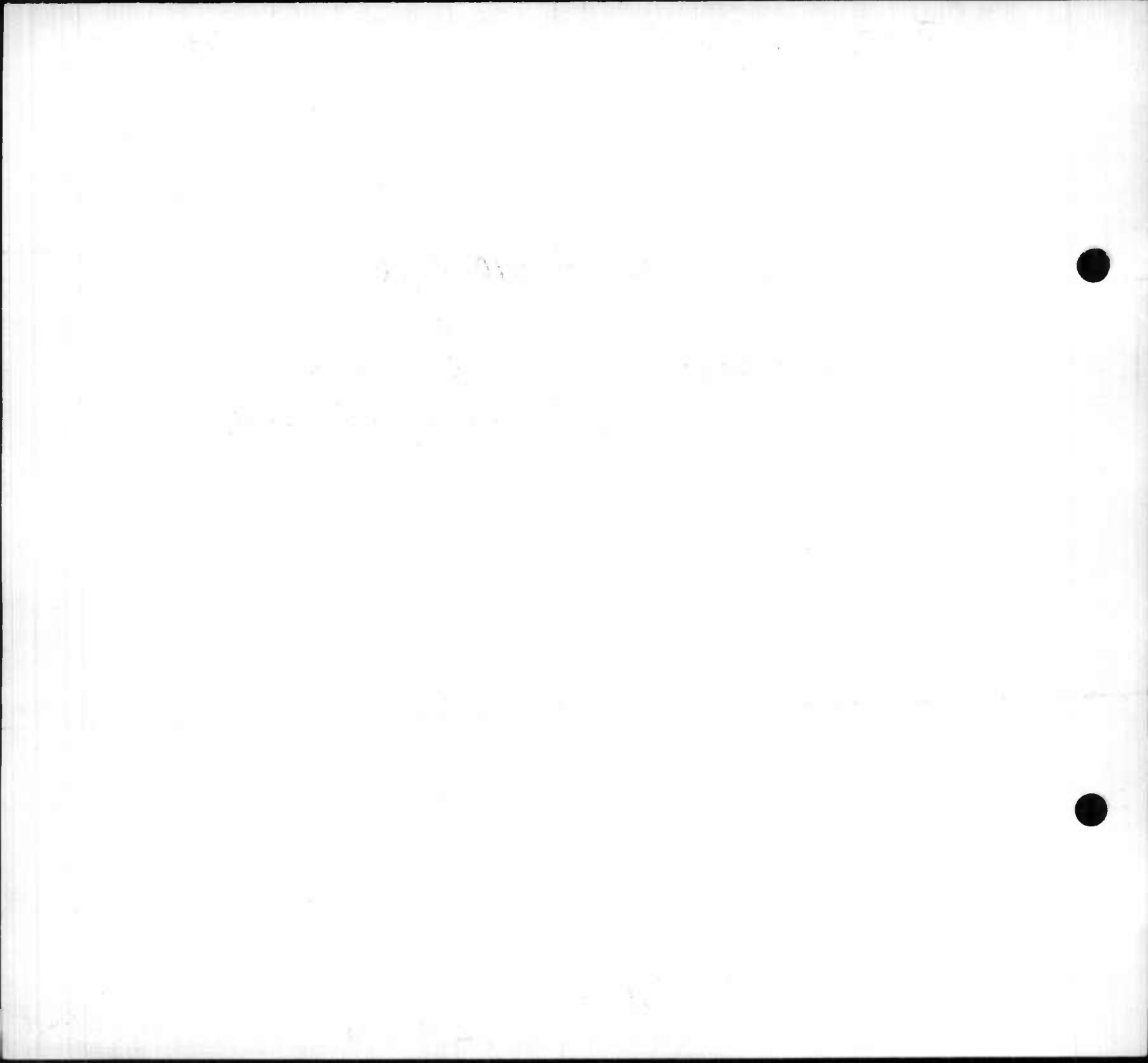
H-400		72 02914		BALTIMORE CITY HEALTH DEPARTMENT		72 02914	
BIRTH NO.		72 02914		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Myrtle I. Healy				March 20, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE			
				Md.			
				2643			
33 Johns Hopkins Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2715 Edison Hgwy.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/12/1898	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SALES LADY -		STEWART & CO -		HANCOCK, MD.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George W. Harr				Carrie E. Malotte			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		212 24 7548		Mr. B. J. Healy		1319 MANTLE ST.	
18. DISEASE OR CONDITION DIRECTLY (LEADING TO DEATH)				CAUSE OF DEATH			
This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
				Acute Myocardial Infarction			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Chronic Heart Disease			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from 10/15/1965 to 3/20/1972 that (I) (we) last saw the deceased alive on 2/15/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Albert B. Bradley				3/21/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Albert B. Bradley, M.D.				4900 Belair Road 21206			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		3/23/72		CATHEDRAL CEM.		BALTO. -	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 24 1972		MICHAEL WIEDERFELD		MICHAEL WIEDERFELD		HOME.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>F-256 72 02915 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02915</p>	
<p>BIRTH NO. F-256</p>		<p>1. NAME OF DECEASED (Type or Print) MARIE M. EGNER</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MD. HOSPITAL BALTO., MD.</p>		<p>2. DATE AND HOUR OF DEATH 3/22/72 9:5 A M.</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2102</p>		<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER 1123 WASHINGTON BLVD.</p>			
<p>5. SEX F 6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 10/28/16 9. AGE (In years last birthday) 55 yrs</p>	<p>10. UNDER 1 Yr. Months: Days: Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY none</p>	
<p>11. BIRTHPLACE (State or foreign country) MD.</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA.</p>	
<p>13. FATHER'S NAME William Claridge</p>		<p>14. MOTHER'S MAIDEN NAME Rose May</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. ✓</p>	
<p>17. INFORMANT Mrs Margaret Claridge</p>		<p>ADDRESS above</p>	
<p>18. CAUSE OF DEATH 571.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) LAENNEC'S CIRRHOSIS</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 yrs</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) ACUTE ALCOHOLIC HEPATITIS 3 wks</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) YES</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 13 Mar. 1972 to 22 MAR 1972 that (I) (we) last saw the deceased alive on 22 Mar. 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE P.A. Mackowiak MD</p>		<p>23B. DATE SIGNED 3/22/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) P.A. MACKOWIAK MD</p>		<p>23D. ADDRESS UNIV. OF MD. HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 3/25/72</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Green Haven Cem.</p>		<p>24D. LOCATION (City, town, or county) (State) Green Haven Md</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972</p>		<p>25B. NAME OF REGISTRAR John J. Green</p>	
<p>25C. FUNERAL DIRECTOR John J. Green</p>		<p>ADDRESS 901 Hollins St. 21225</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-242		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02916	
1. NAME OF DECEASED (Type or Print) Michalak, Helen			2. DATE AND HOUR OF DEATH 3-17-72 7:00 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 705 South Robinson Street 21224		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-93	9. AGE (in years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Marszalkiewicz			14. MOTHER'S MAIDEN NAME Magdalena ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-7307	17. INFORMANT BCH. RECORDS ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224		
18. 444.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE thrombotic phenomena DUE TO, OR AS A CONSEQUENCE OF: (B) None DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
19A. DATE OF OPERATION 3/13			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding		20A. AUTOPSY (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I certify that (I) (this hospital) attended the deceased from 3/13 19 72 to 3/17 19 72 that (I) (we) last saw the deceased alive on 3/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE R. Landau			23B. DATE SIGNED 3/17/72		23C. PHYSICIAN'S NAME (Type) Leon Landau, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3-21-72		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR John Q. Duda		25C. FUNERAL DIRECTOR 2829 Hudson St. Balto. Md. 21224

X

77

EP-12-P

X

Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

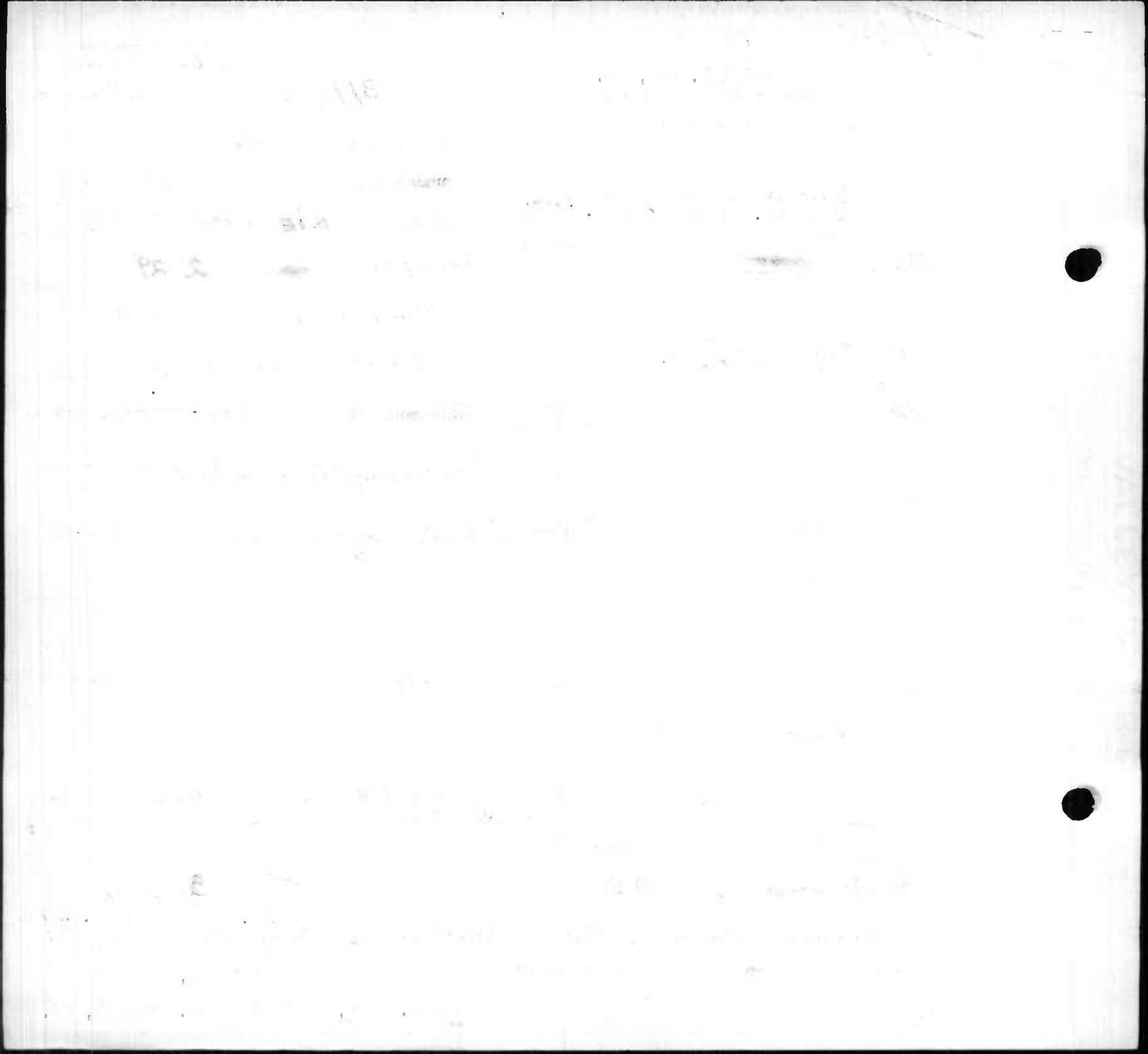
Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

Handwritten text, possibly "Handwritten from 10"

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

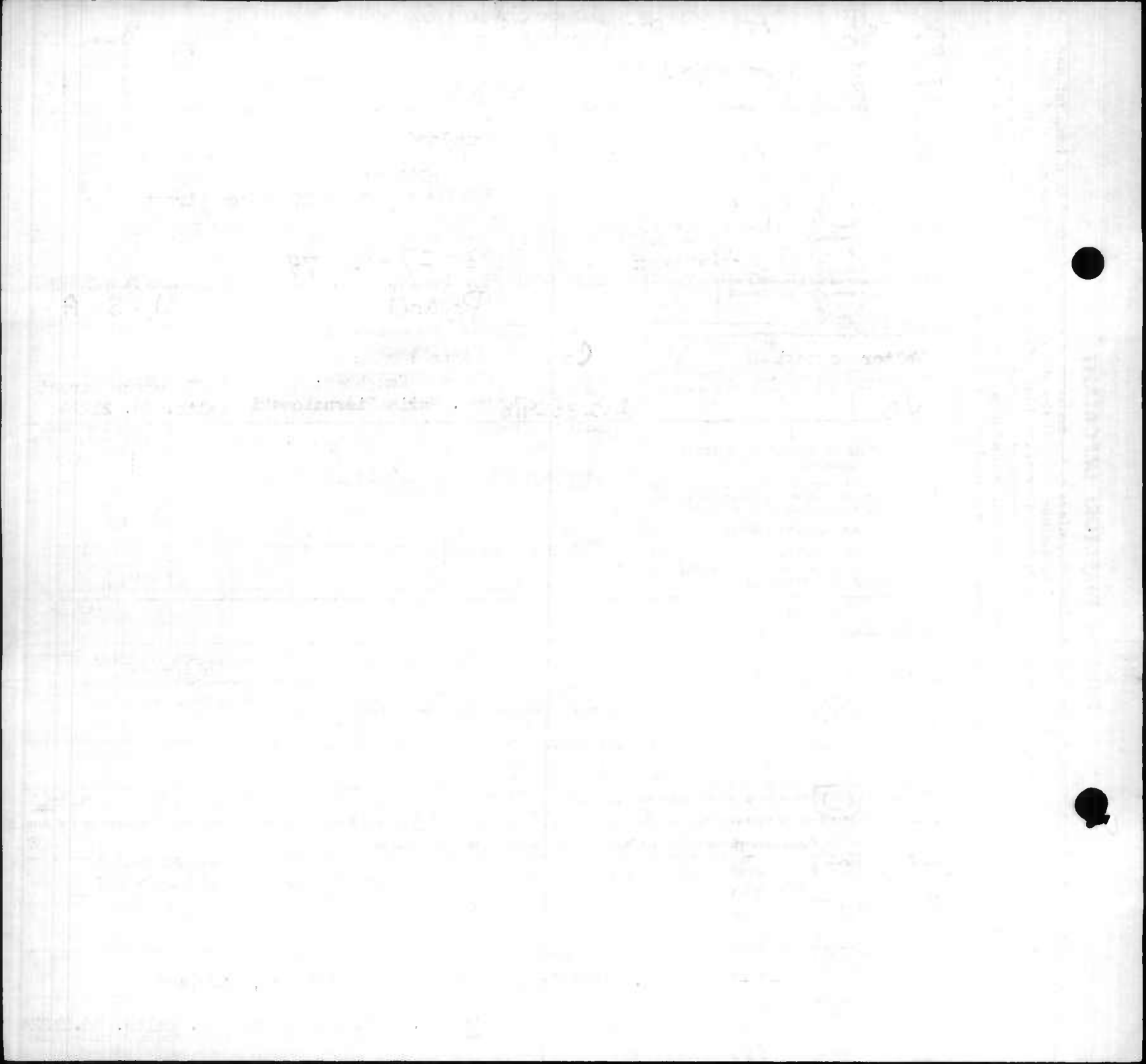
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02918		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02918	
K-532			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) AGNES KENDZEJESKI			2. DATE AND HOUR OF DEATH 03-18-72 1 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 101		
FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital 100 N Broadway St. Baltimore MD 21231			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 03-27-92 9. AGE (In years last birthday) 79		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Poland		
10B. KIND OF BUSINESS OR INDUSTRY none			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Walter Bogucki S. BOGUCKI			14. MOTHER'S MAIDEN NAME Anna ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212 362978		
17. INFORMANT Daughter: Mrs. Marie Biernatowski			18. CAUSE OF DEATH Acute myocardial infarction		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.01			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 90 minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AS.C.M.D - Hypertension			(B) DUE TO, OR AS A CONSEQUENCE OF: Many years		
(C) C.H.F.			Many years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY (Yes or No) none	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> none		21F. HOW DID INJURY OCCUR? none	
22. I certify that (I) (this hospital) attended the deceased from 03-13-1972 to 03-18-1972 that (I) (we) last saw the deceased alive on 03-18-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. J. J. J. J.				23B. DATE SIGNED 03-18-72	
23C. PHYSICIAN'S NAME (Type) Church Home Hospital				23D. ADDRESS Church Home Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-22-72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 2829 Hudson St. Balto. Md. 21224	



CERTIFICATE OF DEATH

REG. NO.

72 02919

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Charles Oscar Lammi, Jr.

CHARLES LAMMI

2. DATE AND HOUR OF DEATH

3/19/72 6²⁰ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

Baltimore City Hospitals
4940 Eastern Ave.
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7431 Holabird Ave. Baltimore, Md. 21222

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-15-88

9. AGE (In years
last birthday)

84

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.
Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Finland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles O. Lammi, Sr.

14. MOTHER'S MAIDEN NAME

Hanna Keele

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

169-07-8160A

17. INFORMANT

BCH Records:

4940 Eastern Ave. ADDRESS

Baltimore, Md. 21224

18. 41241

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

A SCUD

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) Thrombosis of femoral

Pneumonia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

years

12/28/71

1/72

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0 12/28/71

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Thrombosis of femoral

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/28 1971 to 3/19 1972
that (I) (we) last saw the deceased alive on 3/19 1972 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Karen O'Neill

DEGREE

Attending ☐Med. ☐Staff ☒

23B. DATE SIGNED

3/19/72

23C. PHYSICIAN'S
NAME (Type)

Karen O'Neill M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-22-72

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 24 1972

25B. NAME OF REGISTRAR

John J. Duda

25C. FUNERAL DIRECTOR

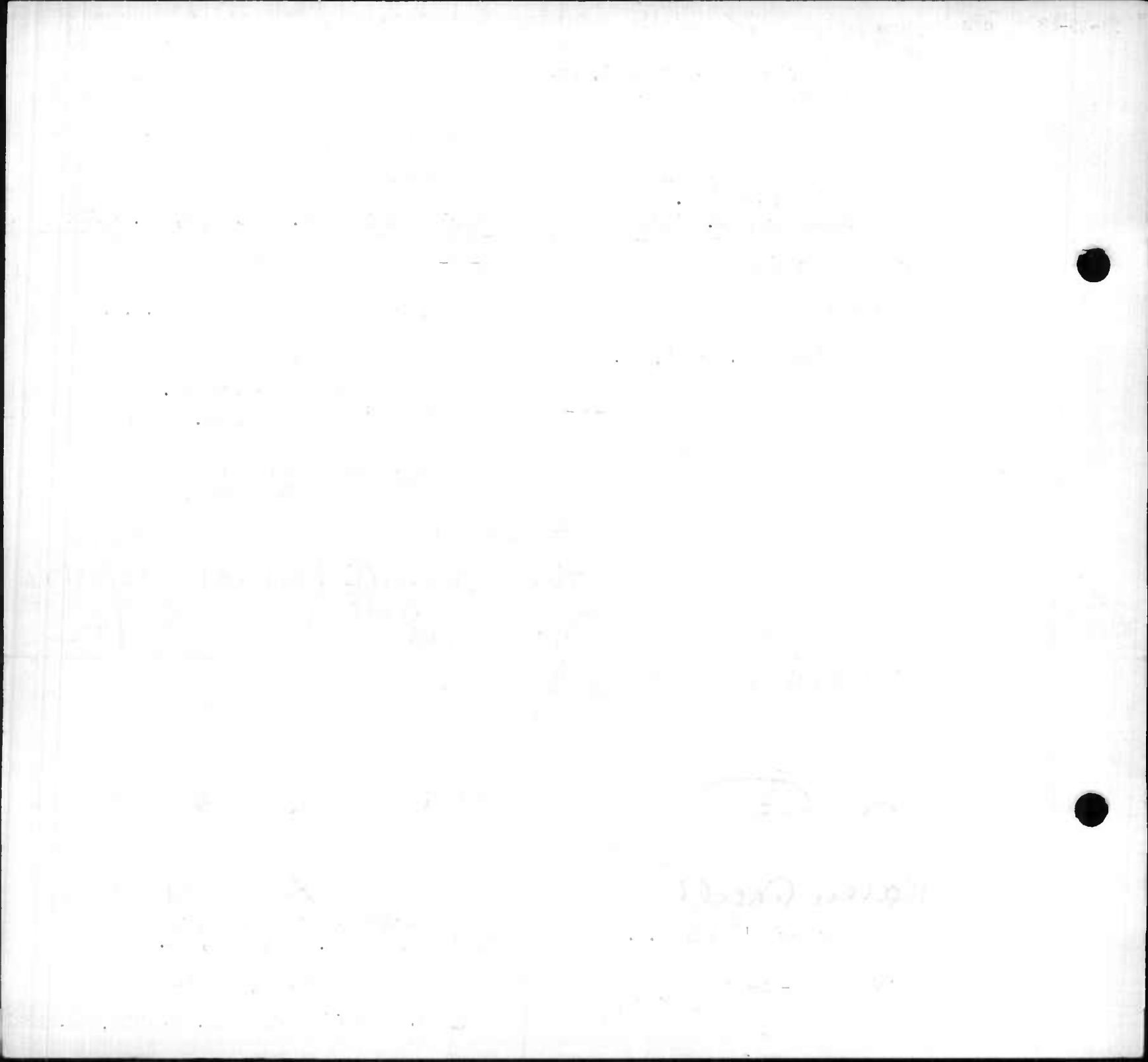
John J. Duda

ADDRESS

7922 Wise Ave. Dundalk, Md. 21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



72 02920

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02920

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH JONES (JOHNSON)

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

March 22,

1972

3:45 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 22,

1972

3:45 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

909

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11-24-53

10. AGE (In years
lost birthda

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1324 Wilcox Street

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward Johnson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Zelma Jones

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Zelma Jones 1324 Wilcox Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Severe hypoxia and pneumonitis

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

~~Severe hypoxia and pneumonitis~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Intravenous narcotism

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate, M.D.
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 23, 1972

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-27-72

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

24D. LOCATION (City, town, or county) (State)

Anne Arundel Cty., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 24 1972

Robert E. Fisher, Jr.

Wm C March

928 E North Ave.

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

WILLIAM FORD

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Edward (McLaurin) McLeaurin		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		Month Day Year Hour 3 13 1972 11:25 a M.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 1867 N. Gay St.		Maryland		Baltimore		806			
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
9. DATE OF BIRTH 12/9/30		10. AGE (In years lost birthday) 41		11 Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER		YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James A. McLeaurin		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Bertha Wright	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		17. SOCIAL SECURITY NO. 217-24-3504		18. INFORMANT Helen Green		ADDRESS 1935 E North Ave.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of the liver		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-13-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Wm C March		ADDRESS 928 E North Ave.			

RECEIVED

MAR 11 1964

100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02922	
T-260 72 02922				REG. NO.	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
TUCKER, Eva M.			3/20/72		9:10 a. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE & COUNTY		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			Maryland		
33 The Johns Hopkins Hospital			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1830 Rutland Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/15/13	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic		At Home		Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Alex Harris			Creola Harris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		28-05-4920HA		MOUNTAIN ROAD ADDRESS	
				Stasadena	
				Md. 21122	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Cardiogenic Shock		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			(B) Myocardial Infarction		
			(C) Electrolyte imbalance, ketoacidosis		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/19 1972 to 3/20 1972 that (I) (we) last saw the deceased alive on 3/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Martha L. Kopper MD				3/20/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Martha L. Kopper, M.D.				Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3-24-72		Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 24 1972		Robert E. [unclear]		Ralph J. Collick	
				2431 E. Oliver St.	

Report of the Commissioner of the General Land Office, Department of the Interior, for the year ending June 30, 1902.

Presented to the Senate and House of Representatives at the second session of the Fifty-ninth Congress, in compliance with a resolution of the Senate, passed March 3, 1896, and a resolution of the House of Representatives, passed March 3, 1896.

WASHINGTON: GOVERNMENT PRINTING OFFICE: 1902.

For sale by the Superintendent of Documents, Washington, D. C.

Price, 10 cents.

Entered as second-class matter, June 26, 1895, under No. 109, Postoffice at Washington, D. C., authorized by Act of Congress, October 3, 1878.

Acceptance for mailing at special rate of postage provided for in Act of October 3, 1878, authorized on July 1, 1901.

Postage paid at Washington, D. C.

Copyright, 1902, by the United States Government.

Printed by the Government Printing Office.

Number 109.

For sale by the Superintendent of Documents, Washington, D. C.

Price, 10 cents.

Entered as second-class matter, June 26, 1895, under No. 109, Postoffice at Washington, D. C., authorized by Act of Congress, October 3, 1878.

Acceptance for mailing at special rate of postage provided for in Act of October 3, 1878, authorized on July 1, 1901.

Postage paid at Washington, D. C.

Copyright, 1902, by the United States Government.

Printed by the Government Printing Office.

Number 109.

For sale by the Superintendent of Documents, Washington, D. C.

Price, 10 cents.

Entered as second-class matter, June 26, 1895, under No. 109, Postoffice at Washington, D. C., authorized by Act of Congress, October 3, 1878.

Acceptance for mailing at special rate of postage provided for in Act of October 3, 1878, authorized on July 1, 1901.

Postage paid at Washington, D. C.

Copyright, 1902, by the United States Government.

Printed by the Government Printing Office.

Number 109.

For sale by the Superintendent of Documents, Washington, D. C.

Price, 10 cents.

Entered as second-class matter, June 26, 1895, under No. 109, Postoffice at Washington, D. C., authorized by Act of Congress, October 3, 1878.

Acceptance for mailing at special rate of postage provided for in Act of October 3, 1878, authorized on July 1, 1901.

Postage paid at Washington, D. C.

Copyright, 1902, by the United States Government.

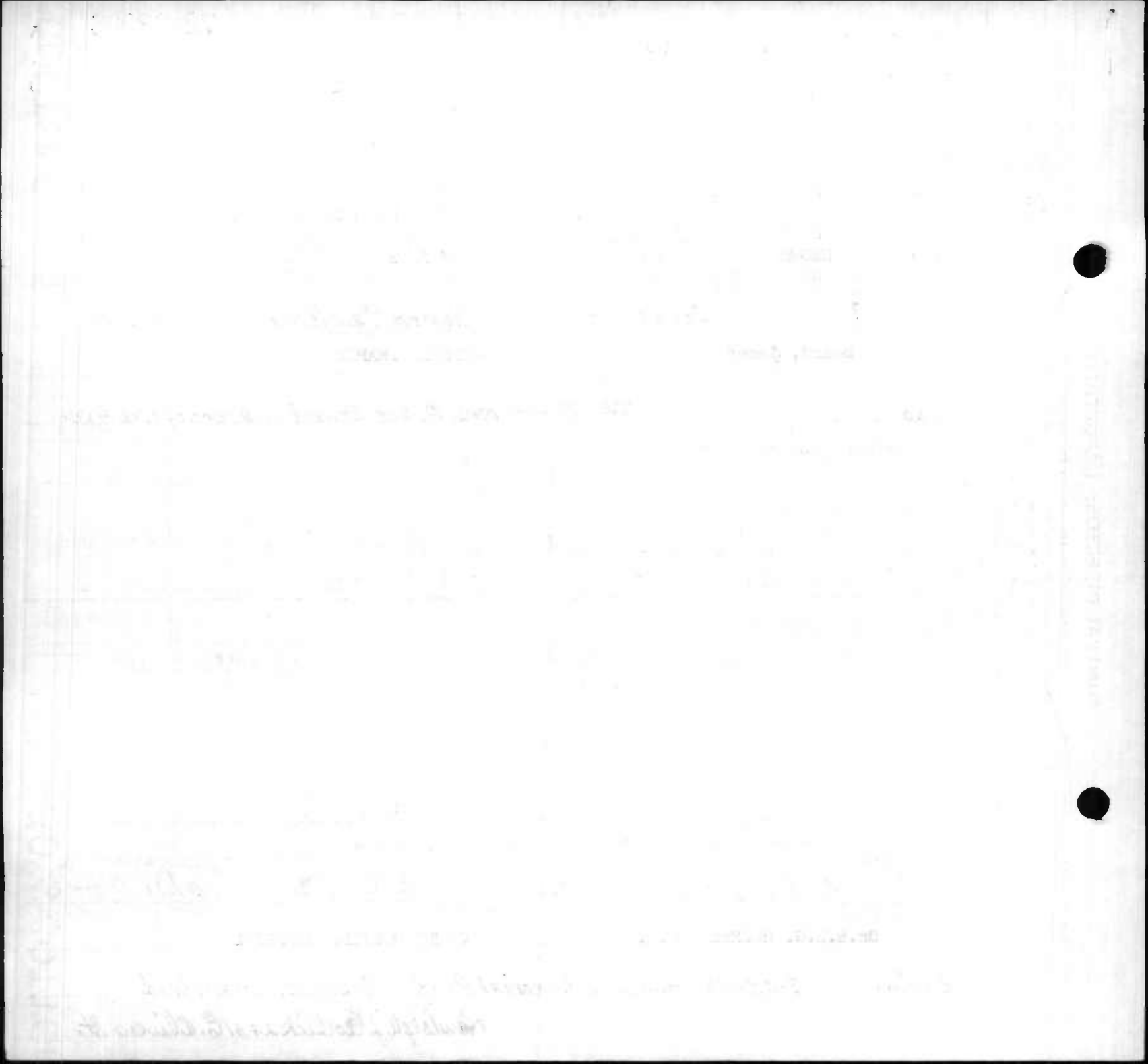
Printed by the Government Printing Office.

Number 109.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

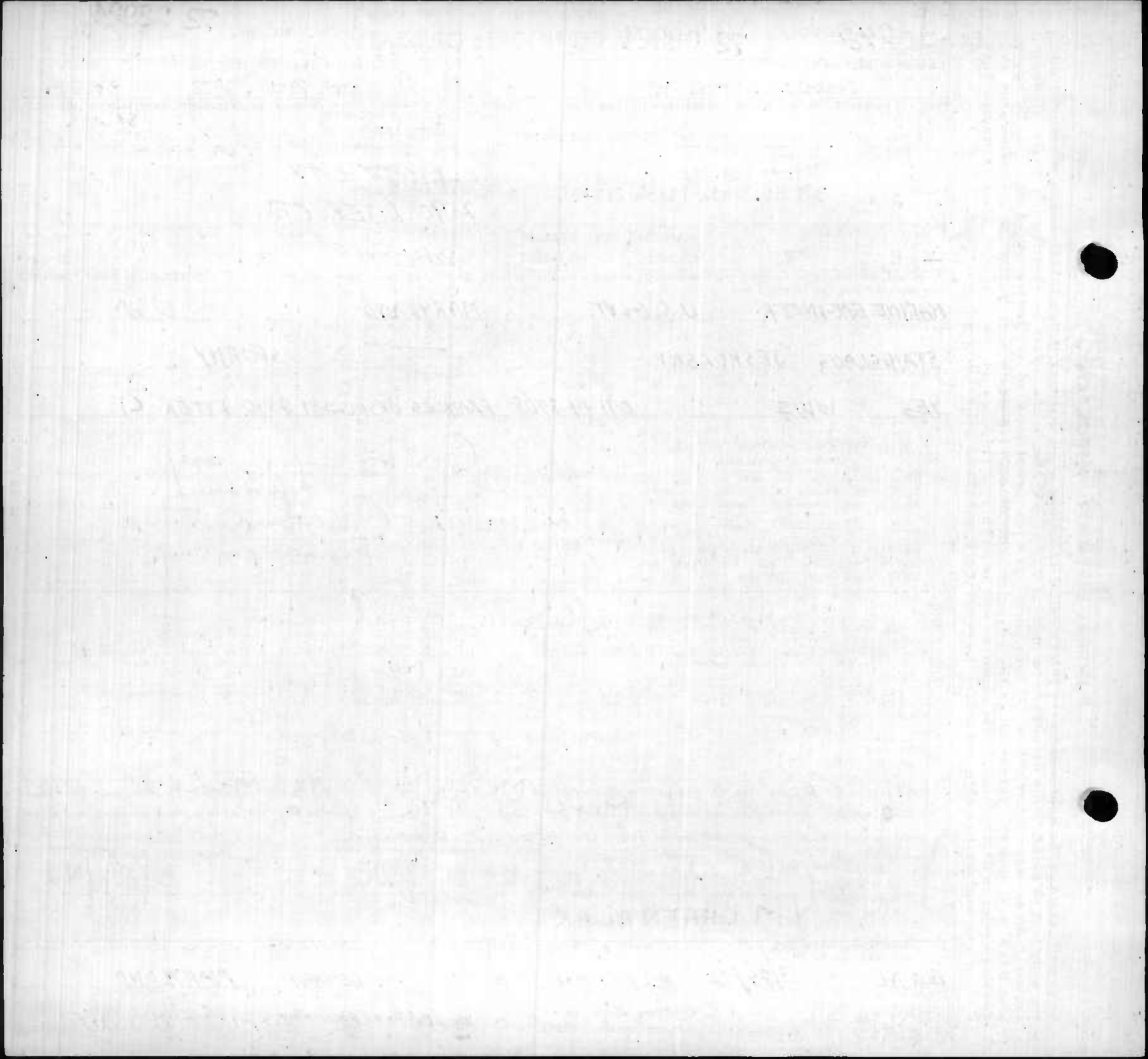
B-630 72 02923				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02923	
1. NAME OF DECEASED (Type or Print) BEARD, DALLAS				2. DATE AND HOUR OF DEATH 03/21/72 2 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 804			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1312 N. MONTFORD AVE.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/03/13		9. AGE (in years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 7			10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Beard, James				14. MOTHER'S MAIDEN NAME JEFFRIES, MAMIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 09 5540		17. INFORMANT Mrs. Grace Beard 1312 Montford Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF:			
				(B) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF:		24 hours	
				(C) CARCINOMA LUNG			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 3/20/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA LUNG		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/18 19 72 to 3/21 19 72 that (I) (we) last saw the deceased alive on 3/21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. C. Holmes M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/21/72	
23C. PHYSICIAN'S NAME (Type) DR. E. E. G. HOLMES M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02924	
BIRTH NO. <div style="font-size: 2em; font-weight: bold;">J-242</div>		<div style="font-size: 2em; font-weight: bold;">72 02924</div> CERTIFICATE OF DEATH			
1. NAME OF DECEASED <small>(Type or Print)</small> <div style="font-size: 1.2em;">Jeskulski, Frank W.</div>			2. DATE AND HOUR OF DEATH <div style="font-size: 1.2em;">March 21st, 1972 1:15 P. M.</div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="font-size: 1.2em;">37 Mercy Hospital 301 St. Paul Place 21202</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="font-size: 1.2em;">Maryland HOWARD 6300</div>		
FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.2em;">37 Mercy Hospital 301 St. Paul Place 21202</div>			5. CITY OR TOWN <div style="font-size: 1.2em;">ELLICOTT CITY</div>		
6. STREET AND NUMBER <div style="font-size: 1.2em;">2590 LITER CT.</div>			D. INSIDE CITY LIMITS? <div style="font-size: 1.2em;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>		
5. SEX <div style="font-size: 1.2em;">M</div>		6. RACE <div style="font-size: 1.2em;">W</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <div style="font-size: 1.2em;">12/6/1900</div>		9. AGE (In years last birthday) <div style="font-size: 1.2em;">71</div>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">MARINE ENGINEER</div>	
11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">MARYLAND</div>		12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em;">U.S.A.</div>		13. FATHER'S NAME <div style="font-size: 1.2em;">STANISLAUS JESKULSKI</div>	
14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">SPORNY</div>		15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> <div style="font-size: 1.2em;">YES WWI</div>		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">091 14 3708</div>	
17. INFORMANT <div style="font-size: 1.2em;">FRANCES JESKULSKI 2590 LITER CT.</div>		18. CAUSE OF DEATH <div style="font-size: 1.2em;">Cardiorespiratory failure. Metastatic Carcinoma primary in lung.</div>		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <div style="font-size: 1.2em;">Hepatic failure.</div>	
20A. AUTOPSY? (Yes or No) <div style="font-size: 1.2em;">No</div>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <div style="font-size: 1.2em;">No</div>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <div style="font-size: 1.2em;">No</div>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <div style="font-size: 1.2em;">No</div>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <div style="font-size: 1.2em;">No</div>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <div style="font-size: 1.2em;">No</div>	
21E. INJURY OCCURRED <div style="font-size: 1.2em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		21F. HOW DID INJURY OCCUR? <div style="font-size: 1.2em;">No</div>		22. I certify that (A) (this hospital) attended the deceased from March 16 1972 to March 21 1972, that (B) (we) last saw the deceased alive on March 21 1972 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (not) view the body after death.	
23A. SIGNATURE <div style="font-size: 1.2em;">Y.M. BHATNAGAR</div>		23B. DATE SIGNED <div style="font-size: 1.2em;">3/21/72</div>		23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Y.M. BHATNAGAR</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">BURIAL</div>		24B. DATE <div style="font-size: 1.2em;">3/25/72</div>		24C. NAME OF CEMETERY or CREMATORY <div style="font-size: 1.2em;">HOLY ROSARY CEMETERY</div>	
24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">DUNDALK MARYLAND</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em;">MAR 24 1972</div>		25B. NAME OF REGISTRAR <div style="font-size: 1.2em;">WEBER FUNERAL HOME</div>	
25C. FUNERAL DIRECTOR <div style="font-size: 1.2em;">WEBER FUNERAL HOME 5311 EDMONDSON AVE</div>		25D. ADDRESS <div style="font-size: 1.2em;">WEBER FUNERAL HOME 5311 EDMONDSON AVE</div>		25E. ADDRESS <div style="font-size: 1.2em;">WEBER FUNERAL HOME 5311 EDMONDSON AVE</div>	



72 02925

BALTIMORE CITY HEALTH DEPARTMENT

N-550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02925

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CURTIS W. NEWMAN, Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 22, 1972 9:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 22, 1972 9:20 P. M.	
6. SEX Male		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-23-1932		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 38		E. STREET AND NUMBER 9 N. Potomac Street	
11. BIRTHPLACE (State or foreign country) VIRGINIA		13. FATHER'S NAME RALEIGH C. NEWMAN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		15. MOTHER'S MAIDEN NAME MONA C. VANDEVANDER	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		14B. KIND OF BUSINESS OR INDUSTRY PAINTING	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 228-40-2425	
18. INFORMANT Mrs. Violet S. Newman - 9 N. Potomac St.		ADDRESS	
19. E-9111X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypoxia DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) Impaction of meat in hypopharynx DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Store (5)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 234 S. Broadway		301	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-18-72 (approx.) 6:20 Pm.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Choked on piece of meat			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 23, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-25-72	
24C. NAME OF CEMETERY or CREMATORY OAK LAWN Cem.		24D. LOCATION (City, town, or county) (State) BALTO, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Walter J. - 2334 Jefferson St.		ADDRESS	

15-150

15-150

15-150

15-150

15-150

15-150

15-150

15-150

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]	
N-435 BIRTH NO.		72 02926		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Nelson, Leroy A.</u>		2. DATE AND HOUR OF DEATH <u>MARCH 19, 1972 5:35 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1510</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital Complex</u> <u>2600 Liberty Heights Ave.</u> <u>Baltimore, Maryland 21215</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>7/4/28</u> 9. AGE (In years last birthday) <u>43</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME <u>Charles Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Henretta Leggett</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-22-6746</u>		17. INFORMANT <u>Mrs. Julia Nelson-Wife</u> ADDRESS <u>Same</u>	
18. <u>23 0 0 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetic mellitus</u> <u>ASCA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypoglycemia & Insulin Admin</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>318-72</u> 19 <u>3/19/72</u> to <u>3/19/72</u> 19 <u>3/19/72</u> that (I) (we) last saw the deceased alive on <u>3/19/72</u> 19 <u>3/19/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Mercado</u> DEGREE				23B. DATE SIGNED <u>Mar. 20, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. G. MERCADO</u>				23D. ADDRESS <u>PROVIDENT HOSP. BALTO. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/23/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Ch. Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>John A. [REDACTED]</u>	
25C. FUNERAL DIRECTOR <u>Richard S. Phillips</u>		25D. ADDRESS <u>1727 N. Monaca St.</u>			

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

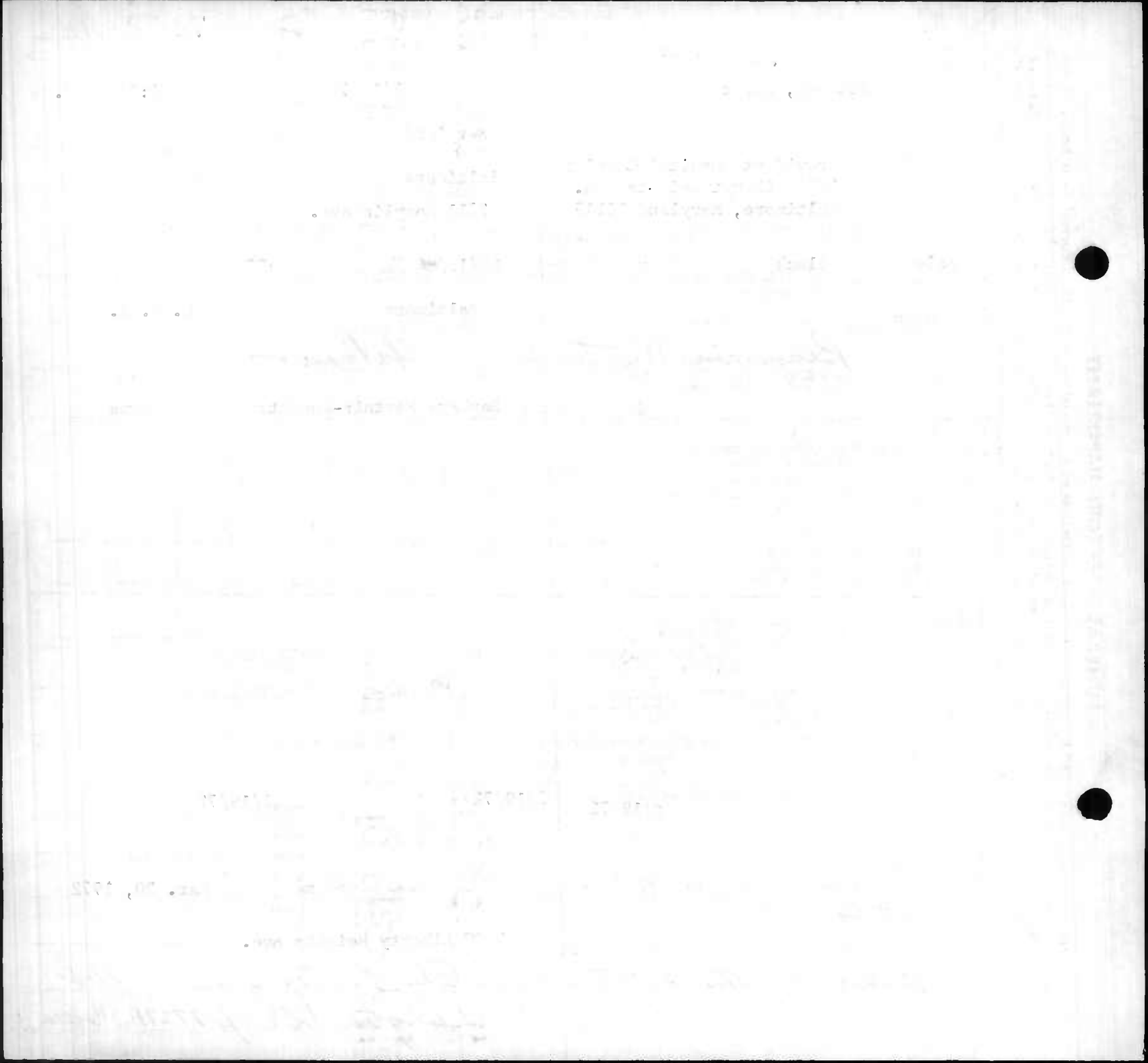
100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> BIRTH NO. M-320 REG. NO. 72 02927 </div>	
<div style="display: flex; justify-content: space-between;"> 1. NAME OF DECEASED (Type or Print) Matthews, Isaac Thomas 2. DATE AND HOUR OF DEATH 3/19/72 4:25 P. M. </div>	
<div style="display: flex; justify-content: space-between;"> 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Provident Hospital Complex 2600 Liberty Heights Ave. Baltimore, Maryland 21215 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1538 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2711 Roslyn Ave. Roslyn </div>	
<div style="display: flex; justify-content: space-between;"> 5. SEX Male 6. RACE Black 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 09/15/26 78 9. AGE (In years last birthday) 93 </div>	
<div style="display: flex; justify-content: space-between;"> 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10B. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Baltimore 12. CITIZEN OF WHAT COUNTRY? U. S. A. </div>	
<div style="display: flex; justify-content: space-between;"> 13. FATHER'S NAME Benjamin Matthews 14. MOTHER'S MAIDEN NAME Unknown </div>	
<div style="display: flex; justify-content: space-between;"> 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None 16. SOCIAL SECURITY NO. 217-07-2237 17. INFORMANT Barbara Martniz-Daughter ADDRESS Same </div>	
<div style="display: flex; justify-content: space-between;"> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 427.21 CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (C) 93 years old. </div>	
<div style="display: flex; justify-content: space-between;"> 19A. DATE OF OPERATION None 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None </div>	
<div style="display: flex; justify-content: space-between;"> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None </div>	
<div style="display: flex; justify-content: space-between;"> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) None 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? None </div>	
<div style="display: flex; justify-content: space-between;"> 22. I certify that (I) (this hospital) attended the deceased from 3/19/72 19 to 3/19/72 19 that (I) (we) last saw the deceased alive on 3/19/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. </div>	
<div style="display: flex; justify-content: space-between;"> 23A. SIGNATURE [Signature] 23B. DATE SIGNED Mar. 20, 1972 </div>	
<div style="display: flex; justify-content: space-between;"> 23C. PHYSICIAN'S NAME (Type) None 23D. ADDRESS 2600 Liberty Heights Ave. </div>	
<div style="display: flex; justify-content: space-between;"> 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/23/72 24C. NAME OF CEMETERY OR CREMATORY Whitman Mem. Pl. Baltimore Md. 24D. LOCATION (City, town, or county) (State) Md. </div>	
<div style="display: flex; justify-content: space-between;"> 25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972 25B. NAME OF REGISTRAR [Signature] 25C. FUNERAL DIRECTOR [Signature] ADDRESS 1727 N. Mount St. </div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 02928	
J-635 BIRTH NO. 72 02523 72 02928				1. NAME OF DECEASED (Type or Print) <u>JORDAN, Robert</u>		2. DATE AND HOUR OF DEATH <u>3/7/72</u> <u>12:20 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2047</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>B</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>2-13-72</u> 9. AGE (In years last birthday) <u>23</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>ROBERT LEWIS</u>	
14. MOTHER'S MAIDEN NAME <u>RENA JORDAN</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rena Jordan</u> ADDRESS <u>Same</u>				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>0541</u> (A) IMMEDIATE CAUSE <u>Cardio Resp. Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Herpes Encephalitis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>-</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased, from <u>2/23</u> <u>1972</u> to <u>3/7</u> <u>1972</u> that (I) <u>last</u> saw the deceased alive on <u>3/7</u> <u>1972</u> and that (in my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.		23A. SIGNATURE <u>Jerrold C. Woodhead, MD</u> 23B. DATE SIGNED <u>3/7/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JERROLD C. WOODHEAD M.D.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/21/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>St. Calvary</u>		24D. LOCATION (City, town, or county) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>2006</u>	
25C. FUNERAL DIRECTOR <u>Phillips 3 Funeral Home Balt, Md.</u>		25D. ADDRESS		25E. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25F. NAME OF REGISTRAR <u>2006</u>	

JEROLD C. WOODHEAD M.D.

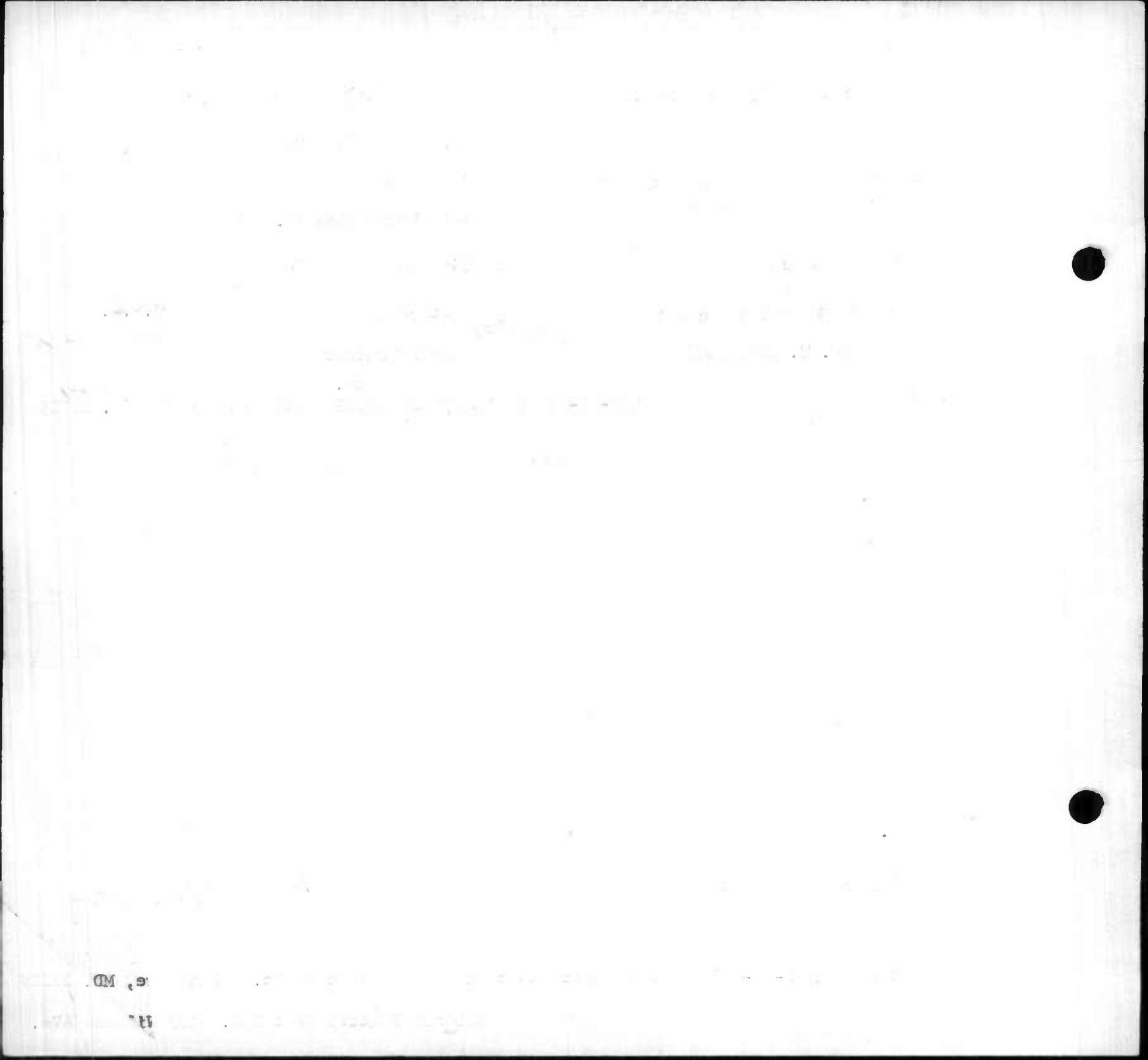
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02929	
BIRTH NO. 72 02929		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SLADKY, THEODORA		2. DATE AND HOUR OF DEATH 3/22/72 11:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2605			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6909 BANK ST. #21224					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-07-86	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN					
13. FATHER'S NAME WESLEY WEBSTER PARSONS		14. MOTHER'S MAIDEN NAME JANIE ANDERSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-26-4398		17. INFORMANT PHILIP W. PARSONS ADDRESS 6909 BANK ST. BALTO., 21224, MD.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio respiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: PROMILASCD - Anemia (C) Acidosis - Azotemia			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-21-1972 to 3-22-1972 , that (I) (we) last saw the deceased alive on 3-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D., DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Ghassan Nahas DEGREE				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-24-72		24C. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) WOODLAWN DRIVE, BALTO. CO., MD.					
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. J. [Signature]		25C. FUNERAL DIRECTOR Charles A. J. [Signature] ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 02930		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02930	
1. NAME OF DECEASED (Type or Print) <u>Mc Connell, William J.</u>			2. DATE AND HOUR OF DEATH <u>3/20/72 at 4:50p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>St. Agnes Hospital Emergency Room</u> <u>900 S. Caton Ave 21229</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>4211 Kensington Rd.</u>		
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1917</u>	9. AGE (in years last birthday) <u>55 54</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal Elementary School</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Wm. T. McConnell</u>			14. MOTHER'S MAIDEN NAME <u>Augusta McNeave</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WW II</u>			16. SOCIAL SECURITY NO. <u>219-07- 3042</u>		17. INFORMANT <u>Mrs. Betty McConnell</u> ADDRESS <u>4211 Kensington Rd. 21229</u>
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Occlusion of Coronary Artery</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. S. Lee</u>			23B. DATE SIGNED <u>3/20/72</u>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3-24-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Wilkins Ave. Baltimore, MD. 21229</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home Inc. 4107 Wilkins Ave.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) E. KENNETH ROBERTS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 8 N. Howard St. Room 510		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 20 1972 10 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1-7-12		10. AGE (In years lost birthday) 60	
11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? CANADA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSIT. MGR.		14B. KIND OF BUSINESS OR INDUSTRY HOTEL (New Howard)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME VIOLET SEATON		18. INFORMANT Lorraine Clifford	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2-25-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-20-72	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-25-72	
24C. NAME OF CEMETERY or CREMATORY ST. PETERS CEM.		24D. LOCATION (City, town, or county) (State) OSWEGO, NEW YORK	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR HOWARD H. HUBBARD		ADDRESS 4107 WILKENS AVE. 21229	

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

WALSH & COMPANY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

HBD		72 02932		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 02932	
BIRTH NO. C-400		1. NAME OF DECEASED (Type or Print) CAHILL, JOHN JOSEPH				2. DATE AND HOUR OF DEATH MARCH 22, 1972 4:00A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL						A. STATE MARYLAND		B. COUNTY BALTIMORE 21227	
						C. CITY OR TOWN ARBUTUS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER 1312 POPLAR AVE. 5300			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05 28 06		9. AGE (In years last birthday) 65		11. BIRTHPLACE (State or foreign country) MARYLAND	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY PEST CONTROL		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN J. CAHILL						14. MOTHER'S MAIDEN NAME ELLEN (COLLINS)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217129246		17. INFORMANT WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from MARCH 22 1972 to MARCH 22 1972 that (X) (we) last saw the deceased alive on MARCH 22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. 23A. SIGNATURE Eitatsu Henzan, M.D. 23B. DATE SIGNED 3/22/72 23C. PHYSICIAN'S NAME (Type) EITATSU HENZAN, M.D. 23D. ADDRESS BALTIMORE, MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3-25-1972 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State) Wilkins Ave. Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972 25B. NAME OF REGISTRAR Hubbard 25C. FUNERAL DIRECTOR Hubbard Funeral Home Inc. ADDRESS 4107 Wilkins Ave.									

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

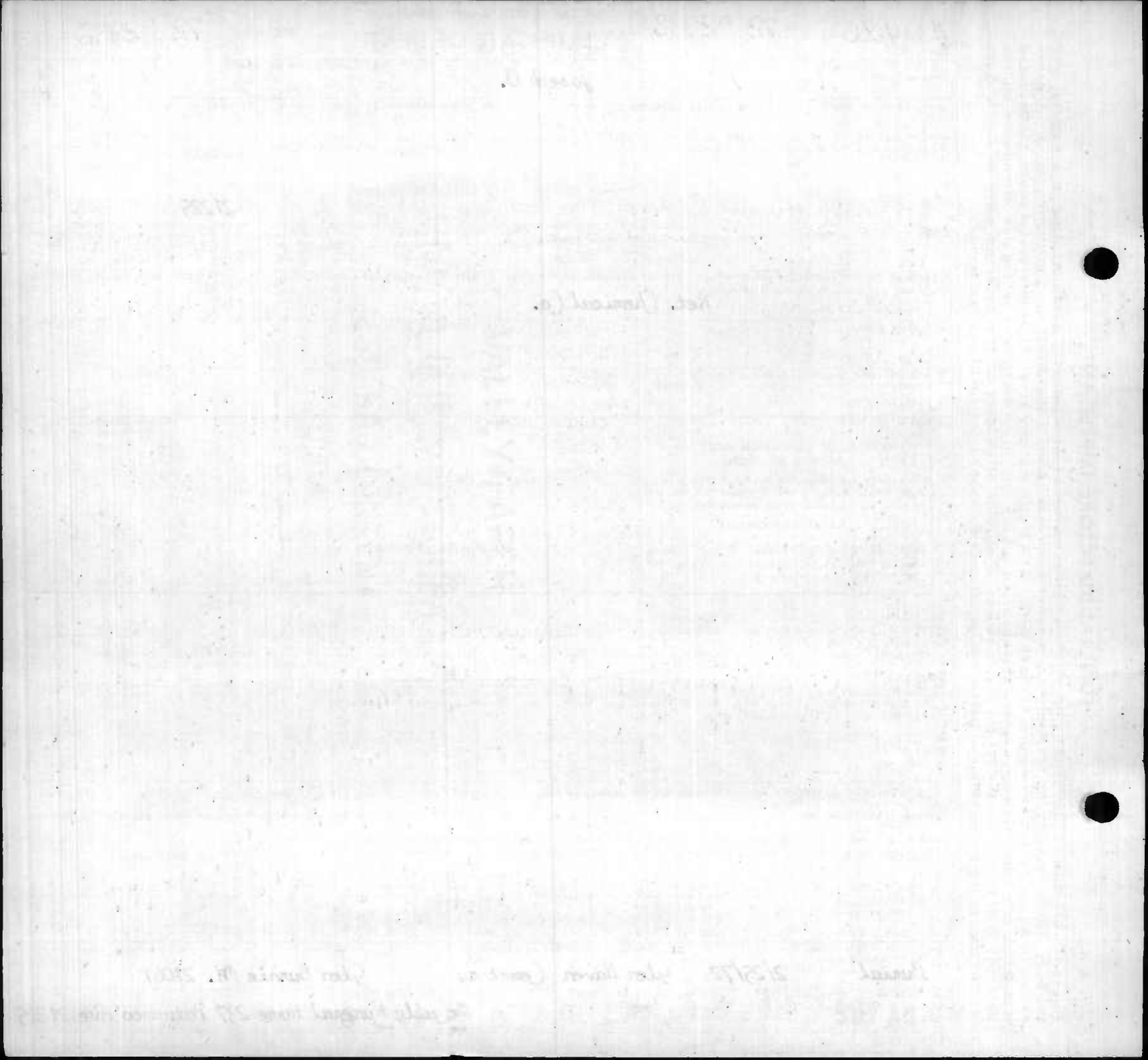
1911

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

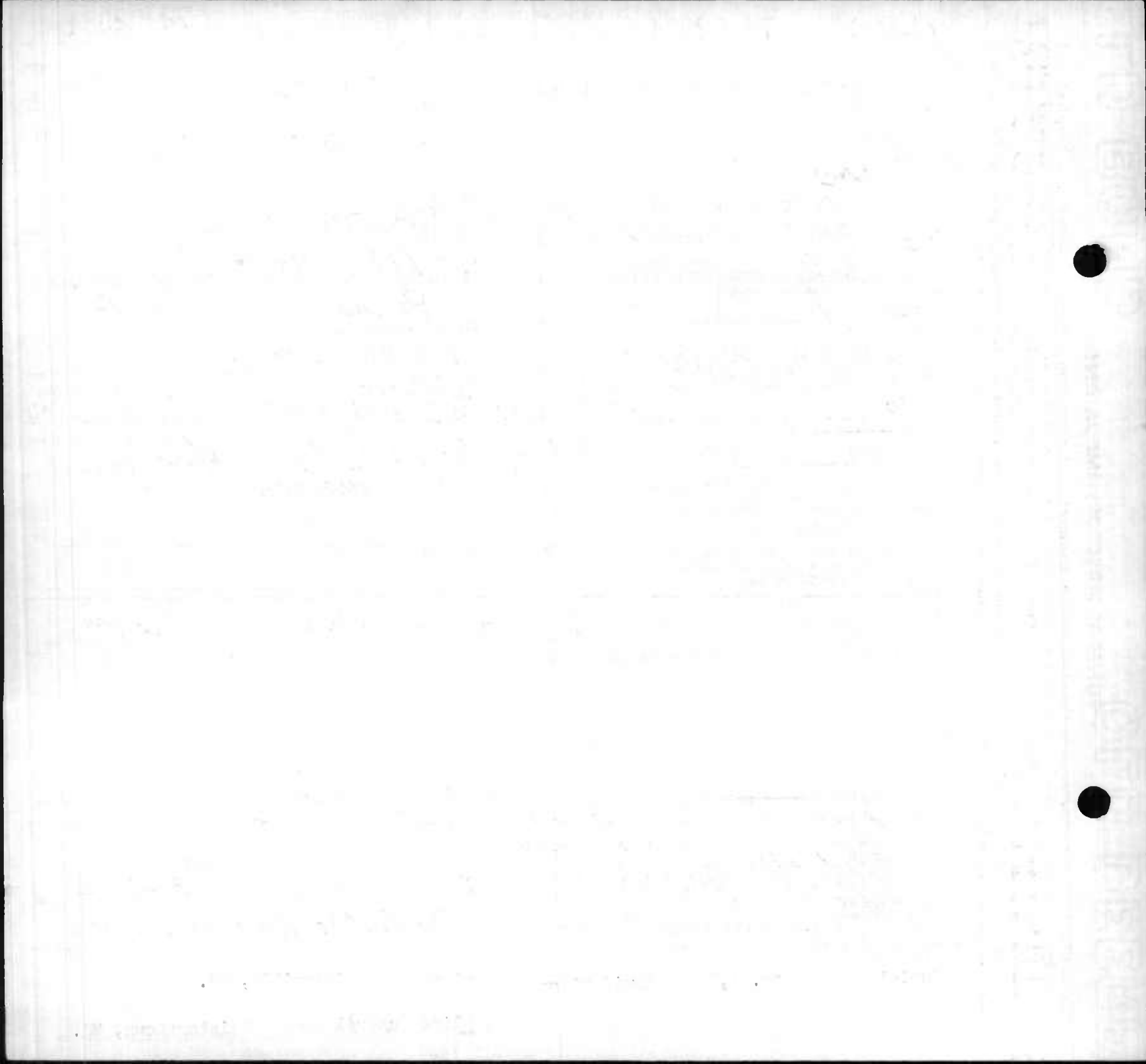
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02933</u>	
W-426 72 02933		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>James Walker Joseph O.</u>			2. DATE AND HOUR OF DEATH <u>3/23/72</u> <u>5:45</u> AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2534</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3820 3rd St.</u> <u>21225</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-92</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Ret. Chemical Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
13. FATHER'S NAME <u>Chalmers</u>			14. MOTHER'S MAIDEN NAME <u>Nona Simpson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>210-09-4783A</u>	17. INFORMANT <u>wife & chart</u>		ADDRESS <u>Same</u>
18. <u>43191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cerebro-Vascular Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> <u>6 days</u> <u>6 days</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Congestive Heart Failure</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3/17</u> 19 <u>72</u> to <u>3/23</u> 19 <u>72</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/22</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Gwynne L. Horwits, M.D.</u>				23B. DATE SIGNED <u>3/23/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gwynne L. Horwits, M.D.</u>				23D. ADDRESS <u>2007 Sulgrave Ave., Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/25/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION <u>Glen Burnie Md. 21061</u>		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>2000</u>		25C. FUNERAL DIRECTOR <u>McCurly Funeral Home</u>	
25D. ADDRESS <u>237 Patapsco Ave 21225</u>		25E. ADDRESS		25F. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

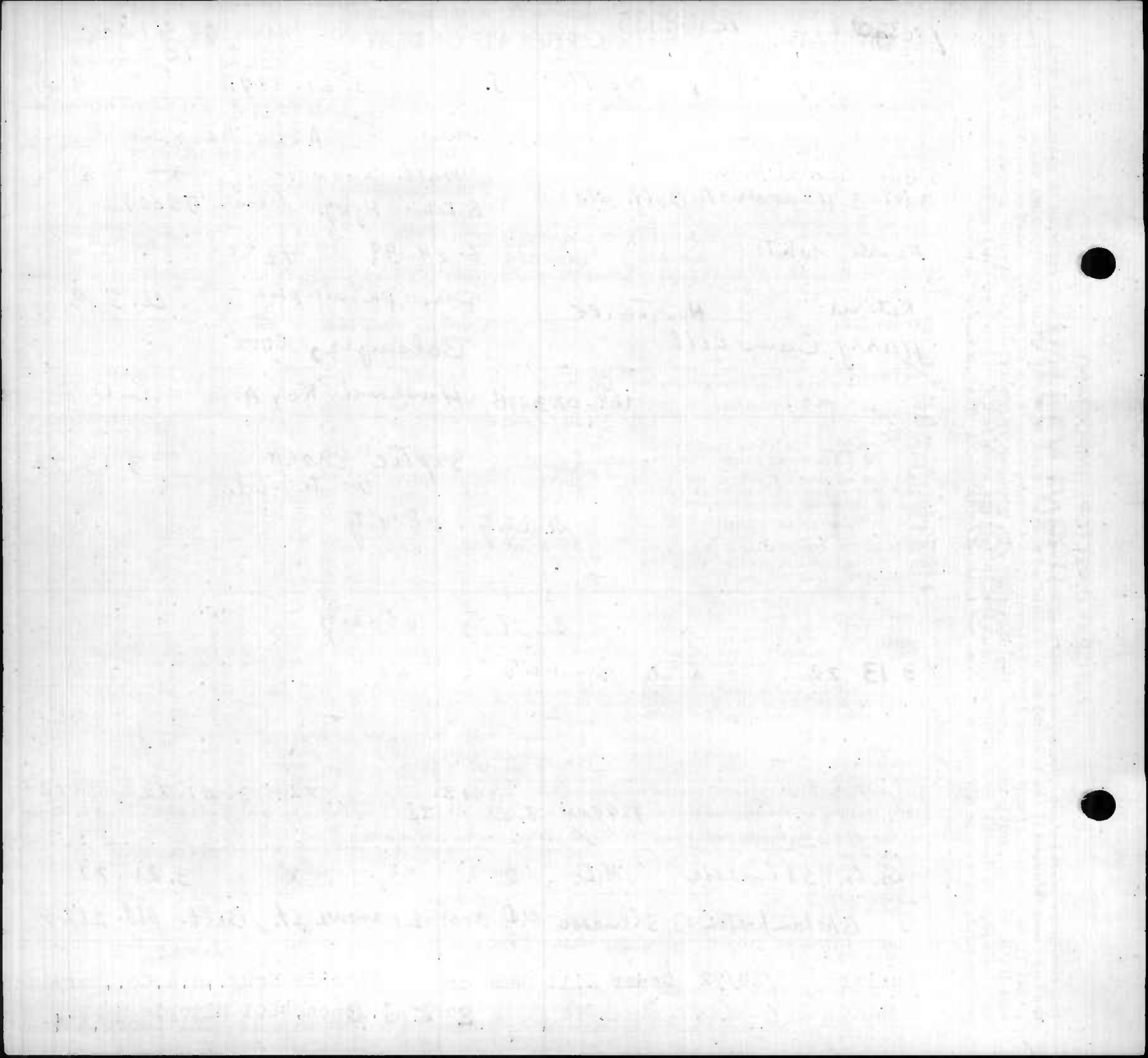
W-410		72 02934		BALTIMORE CITY HEALTH DEPARTMENT		72 02934	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Ada Weikert Wolf</i>				2. DATE AND HOUR OF DEATH <i>3-21-72</i> <i>2³⁰ P.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i> <i>Baltimore Md 21218</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Md</i>		B. COUNTY <i>Baltimore Co</i>	
				C. CITY OR TOWN <i>Reisterstown</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>7 Austin Rd</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/25/97</i>	9. AGE (in years last birthday) <i>74 yrs</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William Weikert</i>				14. MOTHER'S MAIDEN NAME <i>Emma Sheely</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-20-4744</i>		17. INFORMANT <i>Daughter</i> <i>Mrs Shirley Lentzner</i>		ADDRESS <i>16 Aldyth Ave</i> <i>Reisterstown Md</i>	
18. <i>412-41-25019</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic cardio-vascular</i>				<i>gradual</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>disease</i>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes mellitus</i>				<i>18 yrs.</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-29</i> 19 <i>66</i> to <i>3-21</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>3-21</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Alfred G. Ossman Jr MD.</i>				DEGREE <i>MD.</i>		23B. DATE SIGNED <i>3-21-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Alfred G. Ossman Jr MD.</i>		DEGREE <i>MD.</i>		23D. ADDRESS <i>1101 St Paul St Baltimore 2 Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar. 24, 72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 24 1972</i>		25B. NAME OF REGISTRAR <i>Reisterstown</i>		25C. FUNERAL DIRECTOR <i>Elaine Funeral Home</i>		ADDRESS <i>Reisterstown, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

Y-260		72 02935		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 004182	
BIRTH NO. YAUGER, Myrtle J.		CERTIFICATE OF DEATH		72 02935			
1. NAME OF DECEASED (Type or Print) <i>Yauger, Myrtle J.</i>				2. DATE AND HOUR OF DEATH <i>3.21.1972 9 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>ANNE ARUNDEL 5200</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>S. Balt. General Hosp. 3001 S. Hanover St. Balt., Md.</i>				C. CITY OR TOWN <i>Balt. Suburban</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>Ritchie Hwy. (Near 5200)</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6.24.49</i>	9. AGE (In years last birthday) <i>72</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Pa. Philadelphia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry Campbell</i>				14. MOTHER'S MAIDEN NAME <i>Bolsinger, Cora</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no.</i>		16. SOCIAL SECURITY NO. <i>169-073494B</i>		17. INFORMANT <i>Husband Roy A.</i>		ADDRESS <i>Same.</i>	
18. <i>54011</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Septic Shock</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Senility - obesity</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>acute abd.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3.13.72</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Senility - obesity</i>							
19A. DATE OF OPERATION <i>3.13.72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>acute Appendicitis</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>3.13.1972</i> to <i>3.21.72</i> 1972, that (I) (we) last saw the deceased alive on <i>8:45AM 3.21.1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>G. G. Salmassi M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3.21.72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Gholamhossein G. Salmassi M.D.</i>				23D. ADDRESS <i>3001 S. Hanover St., Balt. Md. 21230</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/24/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy., A.A.Co., Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 24 1972</i>		25B. NAME OF REGISTRAR <i>George J. Conce</i>		25C. FUNERAL DIRECTOR <i>George J. Conce</i>		ADDRESS <i>4001 Ritchie Hwy., Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02936</u>	
B-450 72 02936				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE D. BLOME</u>		2. DATE AND HOUR OF DEATH <u>3/24/72</u> <u>4 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u> <u>BALTIMORE, Md</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>6 UPLAND RD</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/91</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. <input type="checkbox"/> 11. Under 24 Hrs. <input type="checkbox"/> Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAWYER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LEGAL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN H. BLOME</u>		14. MOTHER'S MAIDEN NAME <u>CLARA BLANCH</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-22-1687A</u>		17. INFORMANT <u>CATHERINE H BLOME</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u> (B) <u>ASCVD</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>72</u> to <u>3/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael Y. Faulken</u>		23B. DATE SIGNED <u>3/24/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Michael Faulken M.D.</u>		23D. ADDRESS <u>Md. General Hospital, Balto., Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u>		24B. DATE <u>2-27-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	
24D. LOCATION <u>Baltimore</u>		24E. CITY, TOWN, OR COUNTY <u>Md.</u>		24F. STATE <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>R. W. Jenkins & Sons Co., Balto., Md.</u>	

No

John H. Blane

Lawyer

Local

Chattanooga, TN

✓

Clair Blane

Minors

0/12/71

Chattanooga, TN

215-221-1211 Chattanooga H. Blane

Zone

032

No

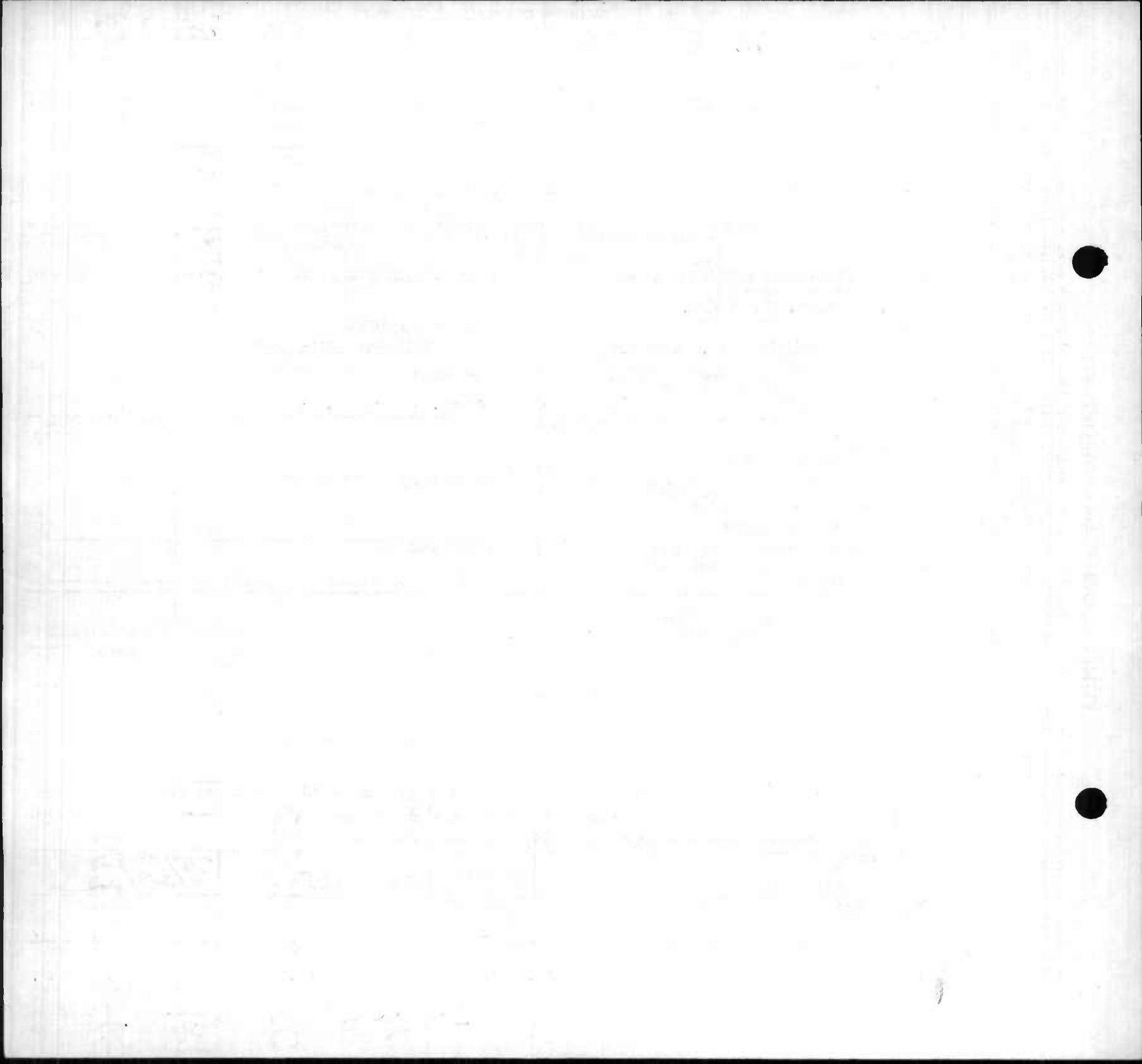
✓

0/12/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-616		72 02937		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02937	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) MR. TAYLOR M. MARBURY				2. DATE AND HOUR OF DEATH 3/23/72 243 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1307			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3925 BEECH AVENUE 21211							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-02	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Balto. Belt Co.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William L. Marbury				14. MOTHER'S MAIDEN NAME Silvine Slingluff			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 579-10-3044		17. INFORMANT Mrs. Mary L. Marbury		ADDRESS Same	
18. 579.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Massive infarction of lung (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Upper & T. bleeding, Colon obstruction						19 days	
19A. DATE OF OPERATION March 17 72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Colon obstruction		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from March 2 19 72 to March 23 19 72 that (X) (we) last saw the deceased alive on March 23 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Yong Hae Lee M.D.				23B. DATE SIGNED 3/23/72		23C. PHYSICIAN'S NAME (Type) YONG HAE LEE M.D.	
23D. ADDRESS 224, E University Parkway, Baltimore, Md.		23E. NAME OF REGISTRAR D O O		23F. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	
24A. BURIAL CREMATION REMOVAL (Specify) Cremation		24B. DATE 3-24-72		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR John E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		BALTIMORE CITY HEALTH DEPARTMENT		72 02938		REG. NO. 72 02938	
BIRTH NO.				72 02938			
1. NAME OF DECEASED (Type or Print) <i>Graham Cora</i>				2. DATE AND HOUR OF DEATH <i>3-23-72 9:50</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Mt. Sinai Nursing Home 4613 Park Heights Ave.</i>				A. STATE <i>Maryland</i> B. COUNTY <i>2101</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>751 W. Hamburg St. 21230</i>							
5. SEX <i>F</i>		6. RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-14-84</i>	
9. AGE (In years last birthday) <i>83</i>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>Augustus Smith</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Berans</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>John A. Graham 751 W. Hamburg St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Auto Passive Congestive Lung</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage & Hemiparesis</i>		<i>6 months</i>	
(C) <i>Rectal Bleeding cause undetermined</i>						<i>4 months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						<i>3 months</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 1972</i> to <i>March 23 1972</i> that (I) (we) last saw the deceased alive on <i>March 23 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Manuel Levin MD</i>				23B. DATE SIGNED <i>3/23/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN M.D.</i>				23D. ADDRESS <i>601 PARK HOTS AVE BALTO MD 21215</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-27-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 24 1972</i>		25B. NAME OF REGISTRAR <i>Charles A. Rice</i>		25C. FUNERAL DIRECTOR'S ADDRESS <i>661 W. Barre St.</i>			

1872

August

August

August 1st

August 2nd

August 3rd

ok

Charles H. Jones
1872

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 02939		72 02939	
BIRTH NO.				72 02939		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Coates Jerome				3-21-72 12 40 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
University of Maryland Hospital				Maryland Baltimore City			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				903 Montgomery Str. 2101			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
male		negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		G-10-14	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
unemployed				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Tom Coates				Annee Coates			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		220-03-3687		Hazel Coates Wife		2611 Garrison Boulevard	
18. 430.0 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Subarachnoid Hemorrhage 30 hrs			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) Hypertension years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Aspiration Pneumonia 24 hrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3-20-72		Subarachnoid hemorrhage					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
no							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED			
22. I certify that (I) (this hospital) attended the deceased from 3-20 19 72 to 3-21 19 72 that (I) (we) last saw the deceased alive on 3-21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Wolfram REICHL				23D. ADDRESS			
23C. PHYSICIAN'S NAME (Type)				Univ. Maryland Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		3-25-72		Mt. Auburn		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAR 24 1972		Charles A. Rice		661 N. Barre St.			

Address does not exist (Coded to last block of Montgomery St.)
Could not get from Hospital of Furman House

YS 151-REV. 1/1/68

EDWARD A. TOLSON JR.

JUNE 26 1947

NEW YORK CITY

TRUCK LEASE COMPANY

YES AND THE TRUCK LEASE COMPANY

BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02941	
BIRTH NO. 72 02941				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) OKSIEN JA MISUK (OR) OCKCELIA MUCUK		2. DATE AND HOUR OF DEATH MARCH 23 1972 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1220 GLYN DOW AVENUE		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2102 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1220 GLYN DOW AVE 21223			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 30 1892	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY TAILOR SHOP		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? 1ST PAPER		13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO -		16. SOCIAL SECURITY NO. 205-03-0742		17. INFORMANT ADDRESS ANNA MIGINSKY 226 PADONTA RD 21093	
18. 15-7-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma Pancreas 1.5-7-91		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION Aug 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Pancreas		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/26 1972 to 3/23 1972, that (I) (we) last saw the deceased alive on 3/22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr. 240				23B. DATE SIGNED 3/24/72	
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR MD				23D. ADDRESS 1227 WASHINGTON BLVD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAR 27-72		24C. NAME OF CEMETERY OR CREMATORY HOLY TRINITY ORTHODOX CEM	
24D. LOCATION ELK RIDGE		24E. HOWARD MD		24F. DATE REC'D BY HEALTH DEPT. MAR 24 1972	
24G. NAME OF REGISTRAR D. J. 9 7 2 0		24H. FUNERAL DIRECTOR D. J. 9 7 2 0		24I. ADDRESS 7110 BELAIR ROAD.	

7-630		72 02942		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 02942	
1. NAME OF DECEASED (Type or Print)		Joseph P. Ford		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month Day Year Hour		3 24 72 5:50 a.m.	
38 University Hospital				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY	
				Md.		Charles			
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Waldorf		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
10-3-1952		19		St. Marys County		U.S.A.		Elmer Brown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
Laborer U.S. Steel Indiana Station				Mary C. Ford					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no				Barbara Ford (wife)		Waldorf Md.			
19. E922.10		CAUSE OF DEATH		Gunshot wound of head					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B)		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(C)		DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes			
2									
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		HOME		Rt. #2 Box 195A - Waldorf, Md. 5800	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?		3 24 72 5:40 a.m.		Subject accidentally shot himself.	
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Peter Lipkovic, M.D.								DATE SIGNED 3/24/72	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		3-28-72		St. Josephs		Pomfret Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAR 24 1972		Robert E. Fisher, M.D.		Thomas Funeral Home					

Charles

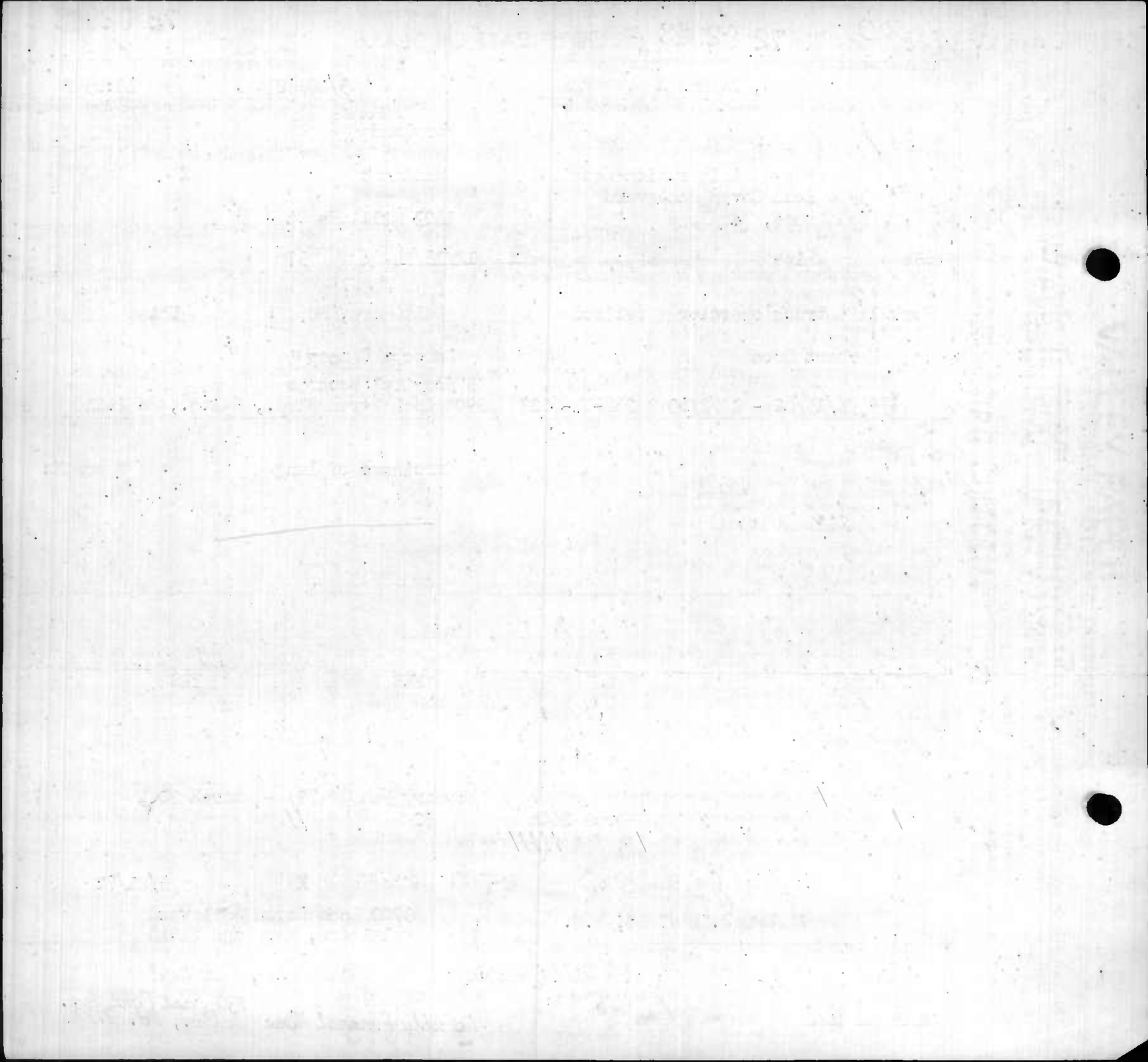
10-2-1922
St. Mary's County, Md.
John C. Jones
Charles Jones

Charles Jones

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02943</u>	
H-300 72 02943		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>HOOD, TAYMAN A</u>			2. DATE AND HOUR OF DEATH <u>3/20/72</u> <u>10:45 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2403</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1423 Williams St</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/16/14</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fork lift truck operator retired</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Herbert Hood</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Chaney</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>5/15/42 - 10/2/43</u>			16. SOCIAL SECURITY NO. <u>218-01-6027</u>		17. INFORMANT <u>VA Hospital Records</u> <u>3900 Loch Raven Blvd., Balto., Md 21218</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u> <u>Carcinoma of lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>February 5th</u> 19 <u>72</u> to <u>March 20th</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>March 20th</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Alfred J. Daniels M.D.</u> DEGREE <u>M.D.</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23C. PHYSICIAN'S NAME (Type) <u>ALFRED J. DANIELS, M.D.</u> DEGREE <u>M.D.</u> 23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> 23B. DATE SIGNED <u>3/21/72</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>3 24 72</u> 24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u> 25B. NAME OF REGISTRAR <u>Charles E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR <u>McCurdy Funeral Home</u> 25D. ADDRESS <u>130 East Fort Ave, Balto., Md. 21230</u>					



M-620

72 02944 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02944

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IRA McKINLEY MORRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 21, 1972 12:30 P.M.	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. DATE OF BIRTH 8/26/1900	10. AGE (In years lost birthday) 71	E. STREET AND NUMBER 175 Cherry Dell Road	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward T. Morris		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipping clerk	
15. MOTHER'S MAIDEN NAME Lillian A.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs Ethel K. Morris 175 Cherrydell Rd.	
19. E815.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Blunt force injury to abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Arteriosclerotic cardiovascular disease	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 5300 Maiden Choice Lane, Catonsville, M.d.	
22D. TIME OF INJURY (APPROX.) 3-16-72 5:05 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Driver in auto fixed object collision		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/22/72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/23/1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.	
25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave.	

75 2014

75 2014

8126/1800

Pennsylvania U.S.A. Edward J. Morris

Shipping clerk Baltimore Business Information

Mr. Edward J. Morris 175 Cherry Hill

WALTER E. HILL

Baltimore, Maryland

3/25/1972 London Park

Encl 1

G. Truman Schwegel 3512 Proctor Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02945	
E-610		72 02945	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Herbert H. Earp</i>		2. DATE AND HOUR OF DEATH <i>March 23, '72</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>35 Church Home & Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>165</i>	
5. SEX <i>M.</i>		6. RACE <i>W.</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/6/14</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Warehouseman</i>		11. BIRTHPLACE (State or foreign country) <i>Ohio</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>Standard Distillers</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>C. F. Earp</i>		14. MOTHER'S MAIDEN NAME <i>Florence Hart</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-7584</i>	
17. INFORMANT <i>Mrs. Gladys B. Earp</i>		ADDRESS <i>2205 E. Baltimore St.</i>	
18. <i>412.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Coronary Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Hypertension with Vascular disease</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wk</i> <i>1 yr</i> <i>10 yrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/4</i> 19 <i>71</i> to <i>3/24</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>3/21</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>S. C. Feldman</i>		23B. DATE SIGNED <i>3/23/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>S. C. Feldman</i>		23D. ADDRESS <i>14406 Balt. Balt. Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/25/72</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAR 24 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>	
25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>		ADDRESS <i>3000 E. Baltimore St.</i>	

20.87 87

20.87 87

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02946</u>	
A-535 72 02946		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Anton, Tamera L</u>			2. DATE AND HOUR OF DEATH <u>3-21-72</u> <u>11:20</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2738</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>601 N. BROADWAY</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>FEMALE</u>			6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>01/14/65</u>			9. AGE (In years last birthday) <u>7</u>		If Under 1 Yr. Months: <u>2</u> Days: <u>7</u> If Under 24 Hrs. Hours: <u> </u> Min. <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>CHARLES ANTON</u>			14. MOTHER'S MAIDEN NAME <u>MARY DALEY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>No ne</u>		17. INFORMANT <u>Charles G. Anton Jr</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PONTINE GLIOMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u> </u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u> </u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>		
19A. DATE OF OPERATION <u>25-11-72 (M)</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>POSTERIOR FOSSA TUMOR</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>NO</u>		21F. HOW DID INJURY OCCUR? <u>NO</u>
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>15 MARCH</u> 19 <u>72</u> to <u>21 MARCH</u> 19 <u>72</u> that <u>(H)</u> (we) last saw the deceased alive on <u>21 MARCH</u> 19 <u>72</u> and that <u>(M)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Karl Stecher, Jr. M.D.</u>			23B. DATE SIGNED <u>3-21-72</u>		23C. PHYSICIAN'S NAME (Type) <u>KARL STECHER, JR. M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>3/24/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. ...</u>			25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>		
25D. ADDRESS <u>Home 6500 York Rd.</u>					

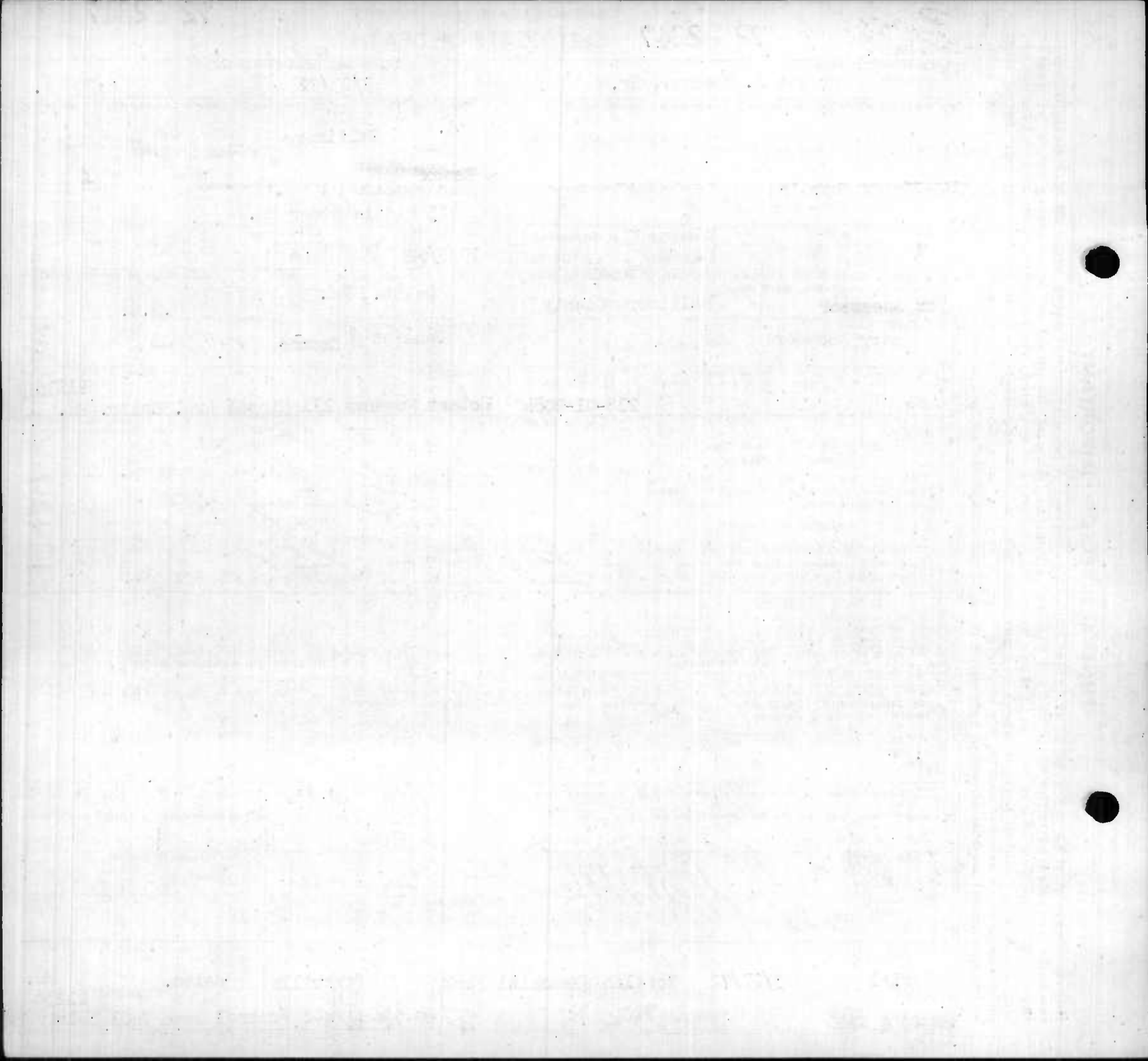
Oper. 5/11/71 Per hospital

17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. R-256		BALTIMORE CITY HEALTH DEPARTMENT		72 02947		CERTIFICATE OF DEATH		72 02947	
1. NAME OF DECEASED (Type or Print) Ernest J. Roesner, Sr.				2. DATE AND HOUR OF DEATH 3/23/72				6:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore				5300	
5. SEX M				6. RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH 10/8/05				9. AGE (In years last birthday) 66				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax Assessor	
11. BIRTHPLACE (State or foreign country) Balto., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Roesner	
14. MOTHER'S MAIDEN NAME Pauline Espano				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-01-2084	
17. INFORMANT Robert Roesner 121 Sippel Ave. Balto. Md.				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.) Bilateral Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cancer of Lung with metastasis Thrombosis of left subclavian artery & veins				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 2				20. AUTOPSY? (Yes or No) YES				21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from 3-14 19 72 to 3-23 19 72				23. SIGNATURE [Signature]				24. DATE SIGNED	
25. DATE REC'D BY HEALTH DEPT. MAR 24 1972				26. NAME OF REGISTRAR [Signature]				27. FUNERAL DIRECTOR [Signature]	
28. ADDRESS 21236				29. ADDRESS 21236				30. ADDRESS 21236	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02948

BIRTH NO.

1. NAME OF DECEASED (Type or Print) P. Stephen Gaisbauer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 3 11 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT in HOSPITAL or INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year 3 11 72		Hour 6:08 p. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2636		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 6603 Gary Avenue	
9. DATE OF BIRTH 2-9-22		10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Not Known		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman	
15. MOTHER'S MAIDEN NAME Theresa ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		17. SOCIAL SECURITY NO. 216-16-2889	
18. INFORMANT Friend: Mrs. Marion E. Barton		19. ADDRESS 1146 Steelton Ave. Balto. Md. 21224		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 3/12/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-24-72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.					

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02949	
S-460 72 02949		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Ralph J. Shuler		3/23/72 8:57 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Balt. - Md.		A. STATE Md B. COUNTY Baltimore	
5. SEX M 6. RACE W		C. CITY OR TOWN Woodlawn D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 7033 Glen Spring Road, 21207	
8. DATE OF BIRTH 10/5/26 9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late Ralph H. Shuler		14. MOTHER'S MAIDEN NAME Julia M. Cure	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 11/10/43-11/4/45		16. SOCIAL SECURITY NO. 136-20-3938	
17. INFORMANT Mrs. Julia Shuler, 7033 Glen Spring Road		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH: RESP. FAILURE + HEPATORENAL SYNDROME		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BLEEDING (B) DUE TO, OR AS A CONSEQUENCE OF: ESOPHAGEAL VARICES (C) NUTRITIONAL CIRRHOSIS		3-4 mos YRS	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING ESOPH. VARICES	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 2/18 1972 to 3/23 1972 that (2) (we) last saw the deceased alive on 3/23 1972 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE J. M. Pardo		23B. DATE SIGNED 3/23/72	
23C. PHYSICIAN'S NAME (Type) JUAN M. PARDO MD		23D. ADDRESS M G H	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/72	
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Ralph E. Shuler	
25C. FUNERAL DIRECTOR Witzke, 1639 Edmondson Ave., 21228		ADDRESS	

1. The first part of the document discusses the background of the case and the parties involved. It mentions that the case was filed in the United States District Court for the District of Columbia on January 15, 2015. The parties are the United States of America, represented by the Department of Justice, and the American Civil Liberties Union (ACLU).

2. The second part of the document discusses the legal issues at stake. It mentions that the case involves the constitutionality of the National Security Agency's (NSA) surveillance programs. The ACLU argues that these programs violate the Fourth Amendment's protection against unreasonable searches and seizures. The United States argues that the programs are necessary for national security and are authorized by the President.

3. The third part of the document discusses the court's decision. It mentions that the court has ruled in favor of the ACLU, finding that the NSA's surveillance programs are unconstitutional. The court has ordered the NSA to stop the programs and to destroy any data that has been collected. The United States has filed a petition for a writ of certiorari with the Supreme Court, asking the Court to review the court's decision.

4. The fourth part of the document discusses the implications of the court's decision. It mentions that the decision is a significant victory for civil liberties and will have a major impact on the NSA's surveillance programs. It also mentions that the decision will likely lead to other cases challenging government surveillance programs.

5. The fifth part of the document discusses the future of the case. It mentions that the United States has filed a petition for a writ of certiorari with the Supreme Court, asking the Court to review the court's decision. It also mentions that the ACLU is planning to file a motion for summary judgment with the court, asking the court to grant summary judgment in favor of the ACLU.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-632 72 02950		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02950	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KRETZMER SARAH KRETZMER		2. DATE AND HOUR OF DEATH 3/22/72 9:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL BALTIMORE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3909 CLARKS LA. #15			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/22	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME ABRAHAM BERLIN		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ANDALUSIA Pa. MR. FRANK KRETZMER, 516 BEACONS CT.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphenia, etc. It means the disease, injury or complication which caused death.) 436917-25019 CAUSE OF DEATH Brain stem CVA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETES MELLITUS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/21/72 to 3/22/72 and that (I) (we) last saw the deceased alive on 3/22/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Armando C. Dinamico, M.D.		23B. DATE SIGNED 3/22/72		23C. PHYSICIAN'S NAME (Type) ARMANDO C. DINAMICO, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-24-72		24C. NAME OF CEMETERY or CREMATORY MOGAN ABRAHAM	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
24D. LOCATION ROSEDALE, MARYLAND		24E. LOCATION (City, town, or county) (State)			

12

12

12

12

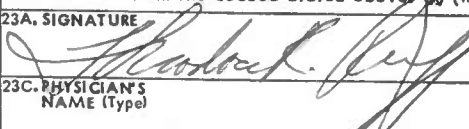
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 02951</u>	
BIRTH NO. <u>N-240</u>		72 02951 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Nickel, Hebeve, C</u>		2. DATE AND HOUR OF DEATH <u>3/22/72</u> <u>3 55 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2719</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5604 KEY AVE.</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-07</u>
9. AGE (in years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>FRANCE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. VICTORY CAVICCHIA</u>		14. MOTHER'S MAIDEN NAME <u>XXXXXX FIERLING</u> <u>MARY MADELINE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-14-4159</u>	
17. INFORMANT <u>MR. BENJAMIN I. NICKEL, 5604 KEY AVENUE #21215</u>		ADDRESS	
18. <u>43671</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Death</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>Hemopericardium, Bilateral Pleural Effusions, Renal Failure</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
21A. DATE OF OPERATION <u>2</u>	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21C. AUTOPSY? (Yes or No) <u>Yes</u>	21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> 19 <u>72</u> to <u>3/22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>James Franklin Grim</u>		23B. DATE SIGNED <u>3/22/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JAMES FRANKLIN GRIM</u>		23D. ADDRESS <u>1528 McElherry St Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>3-24-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>NEW HAR SINAI</u>	24D. LOCATION (City, town, or county) (State) <u>OWINGS MILLS, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>	25B. NAME OF REGISTRAR <u>John E. Bay, Jr.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>SOD LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-350		72 02952		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02952	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ABRAHAM WITTEN				2. DATE AND HOUR OF DEATH MARCH 22, 1972 2:50 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2717			
5. SEX MALE				6. RACE WHITE HUMAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAPER HANGER				10B. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		8. DATE OF BIRTH 1-14 -1893	
13. FATHER'S NAME RAPHAEL WITTEN				11. BIRTHPLACE (State or foreign country) RUSSIA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-05-0179A		9. AGE (In years last birthday) 79	
18. 399.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				12. CITIZEN OF WHAT COUNTRY? USA		14. MOTHER'S MAIDEN NAME ALTE PEARL ?	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		17. INFORMANT DR. BENJAMIN WITTEN, 7501 PRINCE GEORGE ROAD #8	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		months	
22. I certify that (X) (this hospital) attended the deceased from April 20 19 70 to March 22 19 72 that (X) (we) lost saw the deceased alive on March 22 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				20A. AUTOPSY? (Yes or No) XXX		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
23A. SIGNATURE 				23B. DATE SIGNED 3-23-1972		23C. PHYSICIAN'S NAME (Type) Theodore R. Reiff MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 3-24-71		24C. NAME OF CEMETERY or CREMATORY HEBREW YOUNG MEN	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972				25B. NAME OF REGISTRAR 0266 E. ...		25C. FUNERAL DIRECTOR SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

ST-5 57

ST-5 57

1957 10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

10 10

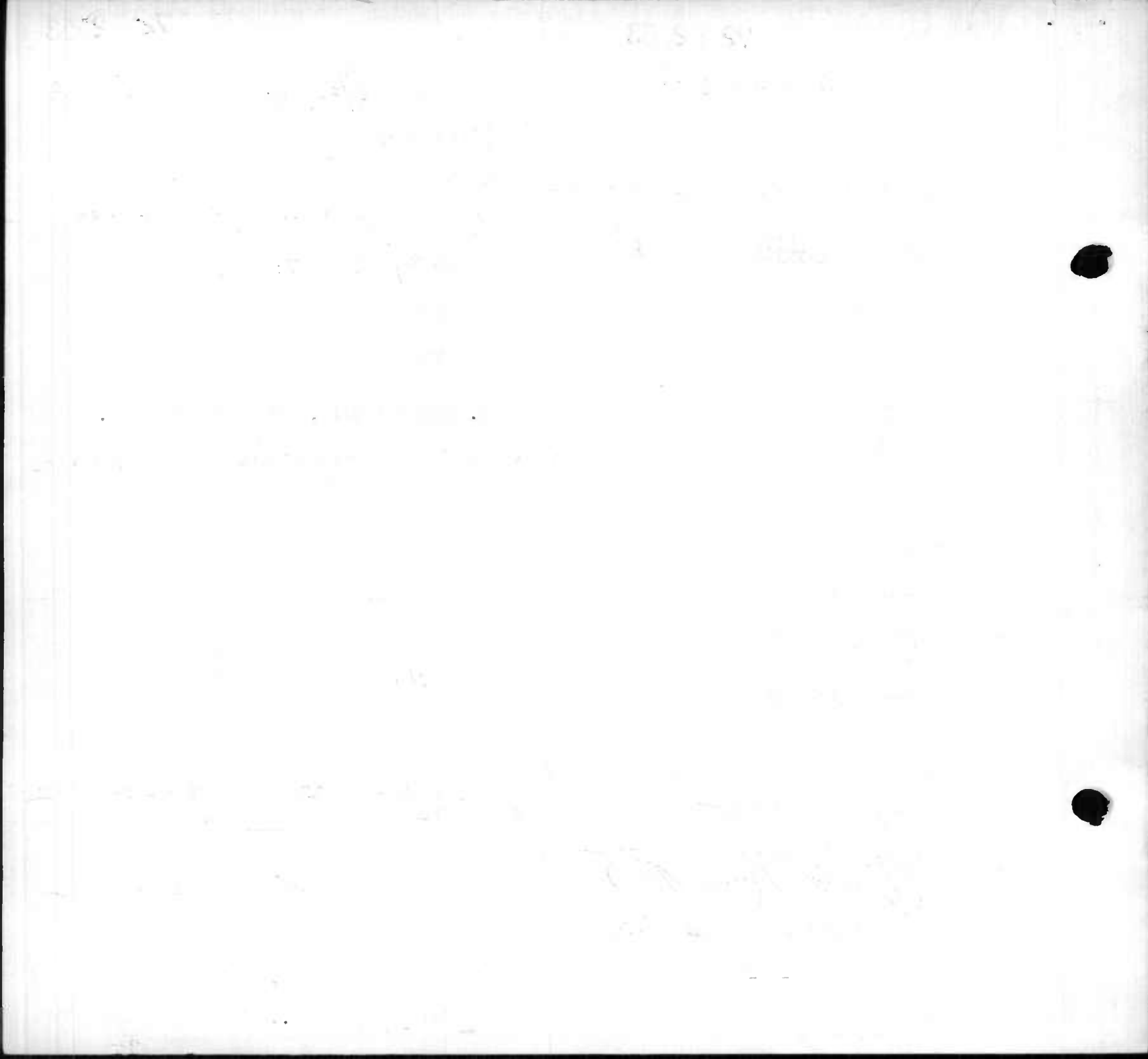
10 10

10 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 02953		72 02953	
BIRTH NO. <u>S-500</u>		CERTIFICATE OF DEATH		REG. NO. _____	
1. NAME OF DECEASED (Type or Print) <u>SCHAIN, EVA</u>		2. DATE AND HOUR OF DEATH <u>3/23/72</u> <u>5⁴⁵ A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2740</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6012 WOODCREST AVE., 21209</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/28/00</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>MOSES ROSEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. ROBERT SCHAIN, 6012 WOODCREST AVE., #21209</u>	
18. <u>15-7-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF PANCREAS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF PANCREAS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>? MONTHS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-11-1972</u> to <u>3-23-1972</u> that (I) (we) last saw the deceased alive on <u>3-23-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mark Cann M.D.</u>		23B. DATE SIGNED <u>3-23-72</u>		23C. PHYSICIAN'S NAME (Type) <u>MARK CANN M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-24-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>AGUDAS ACHIM ANSHE SFARD</u>	
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>			
25B. NAME OF REGISTRAR <u>REG. 302</u>		25C. FUNERAL DIRECTOR <u>SOD LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02954		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02954	
S-350					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>DAVID STEIN</u>		2. DATE AND HOUR OF DEATH <u>3/22/72</u> <u>2:55 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2740</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u> <u>INC.</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>6312 WALLIS AVE. #15</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/22</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SOCIAL SECURITY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>SAMUEL STEIN</u>		14. MOTHER'S MAIDEN NAME <u>IDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-16-3924</u>		17. INFORMANT <u>MRS. SHIRLEY STEIN, 6312 WALLIS AVENUE #21215</u>	
18. <u>431.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		(A) IMMEDIATE CAUSE <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ARTERIAL HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>10 YEARS</u>	
(C) <u>0</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-19-72</u> to <u>3-22-72</u> that (I) (we) last saw the deceased alive on <u>3-22-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>GUERRER</u>		23B. DATE SIGNED <u>3-22-72</u>		23C. PHYSICIAN'S NAME (Type) <u>FELIX GUERRER M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-23-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH TFILOH</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>SQL LEVINSON</u>		25C. FUNERAL DIRECTOR <u>SQL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		24E. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>			

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

1825 55

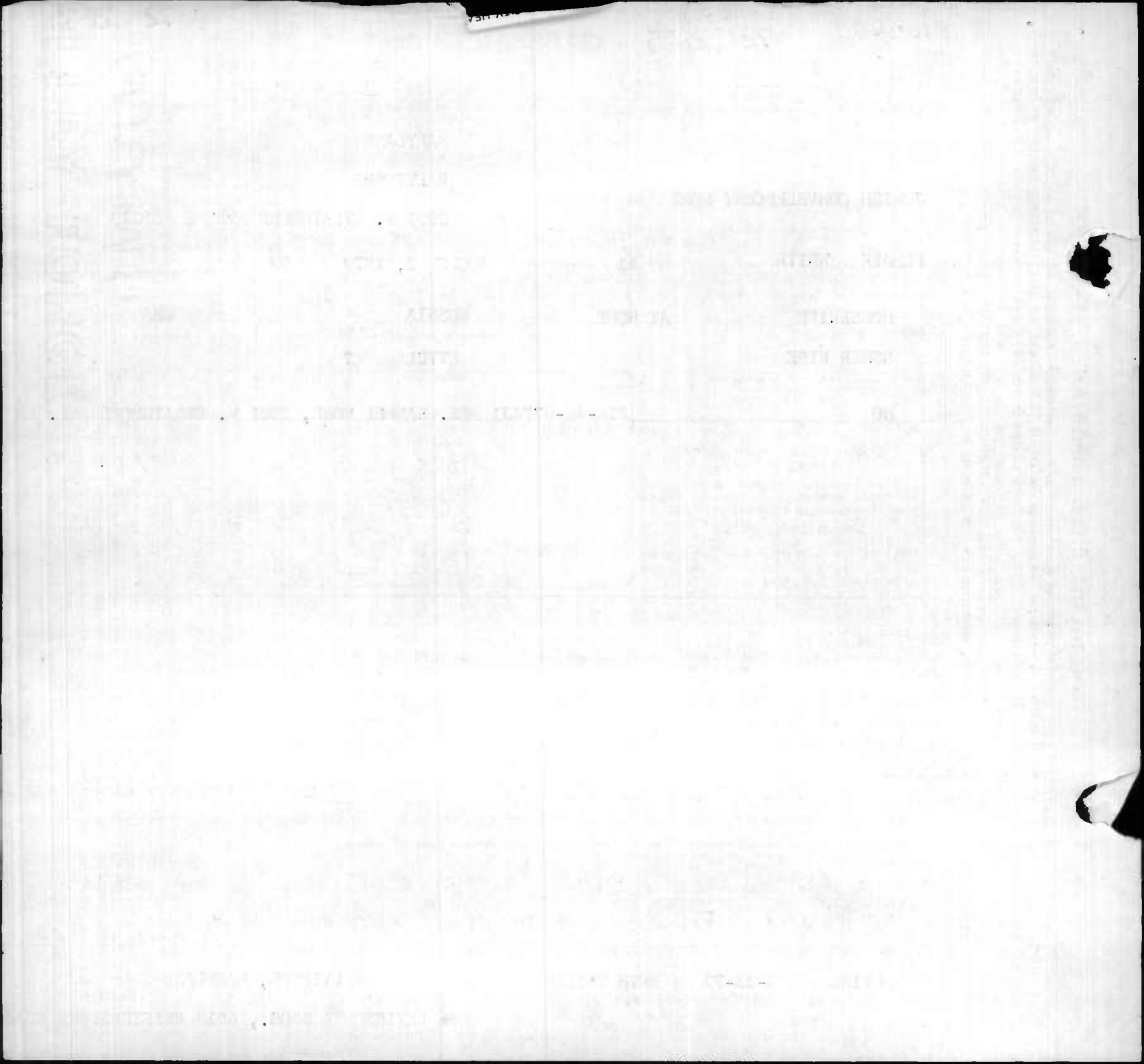
1825 55

1825 55

1825 55

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02955
BIRTH NO. L-200		72 02955		
1. NAME OF DECEASED (Type or Print) ETHEL LISSY		2. DATE AND HOUR OF DEATH 3-22-72 12:00 Noon M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JEWISH CONVALESCENT HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2740 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2901 W. STRATHMORE AVENUE #21209		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 2, 1879	9. AGE (In years lost birthday) 92
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME USHER WISE		14. MOTHER'S MAIDEN NAME ETTEL ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-46-0774J1		17. INFORMANT MRS. SAMUEL ROSE, 2901 W. STRATHMORE AVE. #9
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 174X I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic Ca.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Ca of Lft heart		2 years
(C) inoperable				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) N/A	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1946 to 3-22-72 19 72 , that (I) (we) last saw the deceased alive on 3/21/72 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE A. A. Silver		23B. DATE SIGNED 3-22-72		
23C. PHYSICIAN'S NAME (Type) A. A. SILVER MD		23D. ADDRESS 6210 PARK HEIGHTS AVE. Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-23-72	24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972	25B. NAME OF REGISTRAR 000	25C. FUNERAL DIRECTOR ADDRESS SGE LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-626 72 02956				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02956	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HENRY BERGER				2. DATE AND HOUR OF DEATH 03/22/72 1:45A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 601 N. BROADWAY		A. STATE MARYLAND		B. COUNTY 2633	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3300 CHESTERFIELD AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/22/12	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SIMON BERGER				14. MOTHER'S MAIDEN NAME MARY ORALOVWITZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II				16. SOCIAL SECURITY NO. 215 14 5143		17. INFORMANT ADDRESS MRS. MILDRED BERGER, 3300 CHESTERFIELD AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 394.91 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MITRAL VALVE DISEASE				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MITRAL VALVE DISEASE			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CORONARY ARTERY DISEASE							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 3/11/72 to 3/22/72 and that (I) (we) last saw the deceased alive on 3/22/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael K. M.D.				23B. DATE SIGNED 3/22/72		23C. PHYSICIAN'S NAME (Type) Michael K. M.D.	
23D. ADDRESS Johns Hopkins Hosp.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-23-72		24C. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Paul E. Jones, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

ADP

RECEIVED, PROVINCIAL

RECEIVED

RECEIVED

RECEIVED, PROVINCIAL

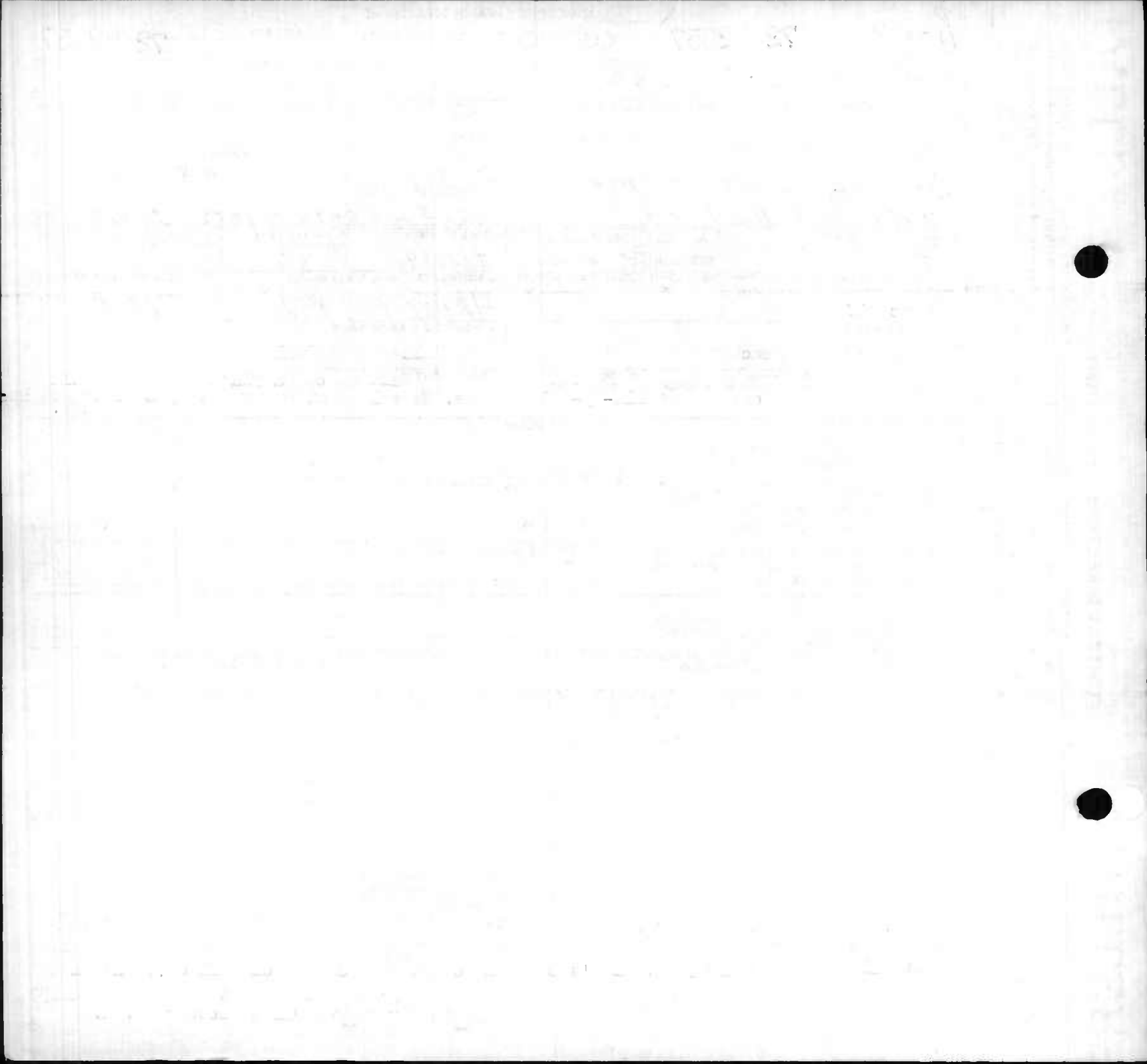
RECEIVED, PROVINCIAL

RECEIVED, PROVINCIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-600 72 02957 CERTIFICATE OF DEATH REG. NO. 72 02957 </div>			
1. NAME OF DECEASED (Type or Print) <u>Uma M. BEUWER</u>		2. DATE AND HOUR OF DEATH <u>3-23-72</u> <u>9 a</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>2802</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Conv. Home</u> <u>4601 Fall mail Rd.</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>4905 Liberty Hghts Ave. 21207</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/91</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>80</u>
11. BIRTHPLACE (State or foreign country) <u>HARNEY md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Menchey</u>		14. MOTHER'S MAIDEN NAME <u>Null</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>112-03-2038</u>	
17. INFORMANT <u>Baltimore, Maryland</u> ADDRESS <u>21207</u> <u>Mrs. Beverly Montgomery</u> <u>4905 Liberty Height Ave.</u>			
18. <u>1997</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CVA</u> <u>2 Malignancy</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u> <u>36 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Feb 13</u> 19 <u>72</u> to <u>3-23-</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>3-21-72</u> 19 <u>72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ardaiz</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Jose ARDAIZ, MD</u>		23D. ADDRESS <u>2802 NORTH POINT Road 21222</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME of CEMETERY or CREMATORY <u>St. Paul's Lutheran Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Harney Carroll Co., Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. Byers</u>	
25C. FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road 21133</u> <u>Funeral Directors, P. A.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-500 72 02958				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02958	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert Benson Dunn				3/22-72 9:58 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital Caton and Wilkens Ave.				A. STATE Maryland		B. COUNTY Carroll	
				C. CITY OR TOWN Sykesville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Box 210, Rt. 4			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-09	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker		10B. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Benson Mauze Dunn				14. MOTHER'S MAIDEN NAME Eitze (Margaret Eitze)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 445-01-3524		17. INFORMANT Evelyn M. Dunn Same as above			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction .2 hr Cardiopulmonary Arrest-			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 21 1972 to March 22 1972 that (I) (we) last saw the deceased alive on March 22, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M Lanny Fiddigen				23B. DATE SIGNED 3-22-72		23C. PHYSICIAN'S NAME (Type) M. Lanny Fiddigen	
23D. ADDRESS St Agnes Hospital		23E. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23F. LOCATION Elkridge		23G. FUNERAL DIRECTOR Sherry Haight	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-72		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION Elkridge Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Sherry Haight		25C. ADDRESS Sykesville, Md.			

(Municipal Council)

210

2-22-12

1912

Long Bridge

2-22-12

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02959	
4-625		72 02959		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HARRISON, CHARLES W.		2. DATE AND HOUR OF DEATH Mar. 22, '72 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD #2 SINAI HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE M.D. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 8412 Winands Rd #8			
5. SEX M	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1910		9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diesel Engineer - Federal Employee		10B. KIND OF BUSINESS OR INDUSTRY Panama Canal Co.		11. BIRTHPLACE (State or foreign country) Gorgona Canal Zone	
13. FATHER'S NAME Thomas William Harrison		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-44-2790		17. INFORMANT Mrs. Robin Walker	
				ADDRESS 8412 Winands Road 21208	
18. 199.1		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Terminal, Ca.		unknown.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2 NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16/72 19 72 to 3/22 19 72 that (I) (we) last saw the deceased alive on 3/21/ 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jacob August		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/22/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 3/23/1972		24C. NAME of CEMETERY or CREMATORY Loudon Park Crematory	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21135 Loring Byers Funeral Directors, P. A.	

1881

1881

...

...

...

...

...

...

...

...

...

...

...

...

...

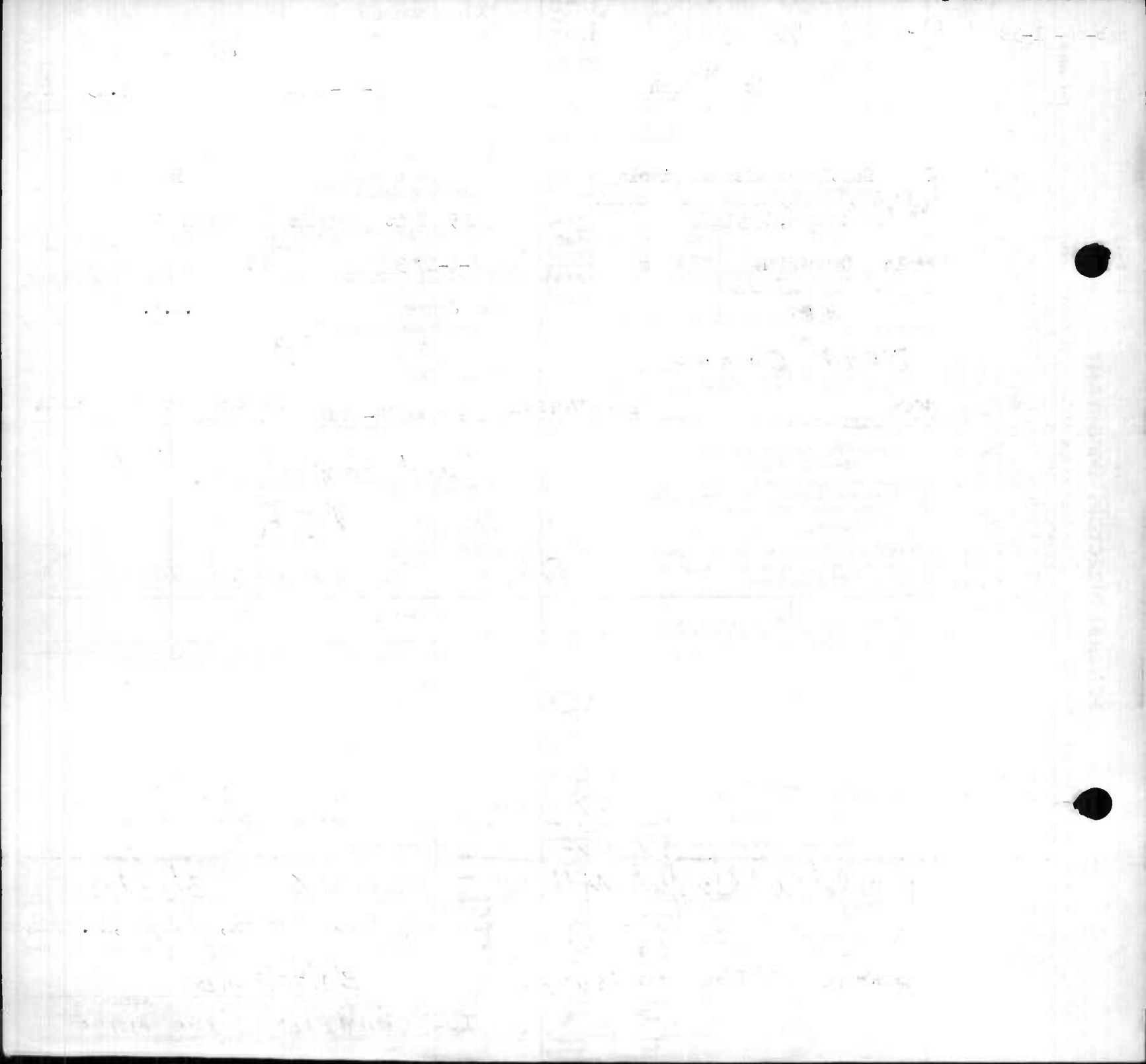
...

138-81-60-sab

FUNERAL DIRECTOR: IMPORTANT

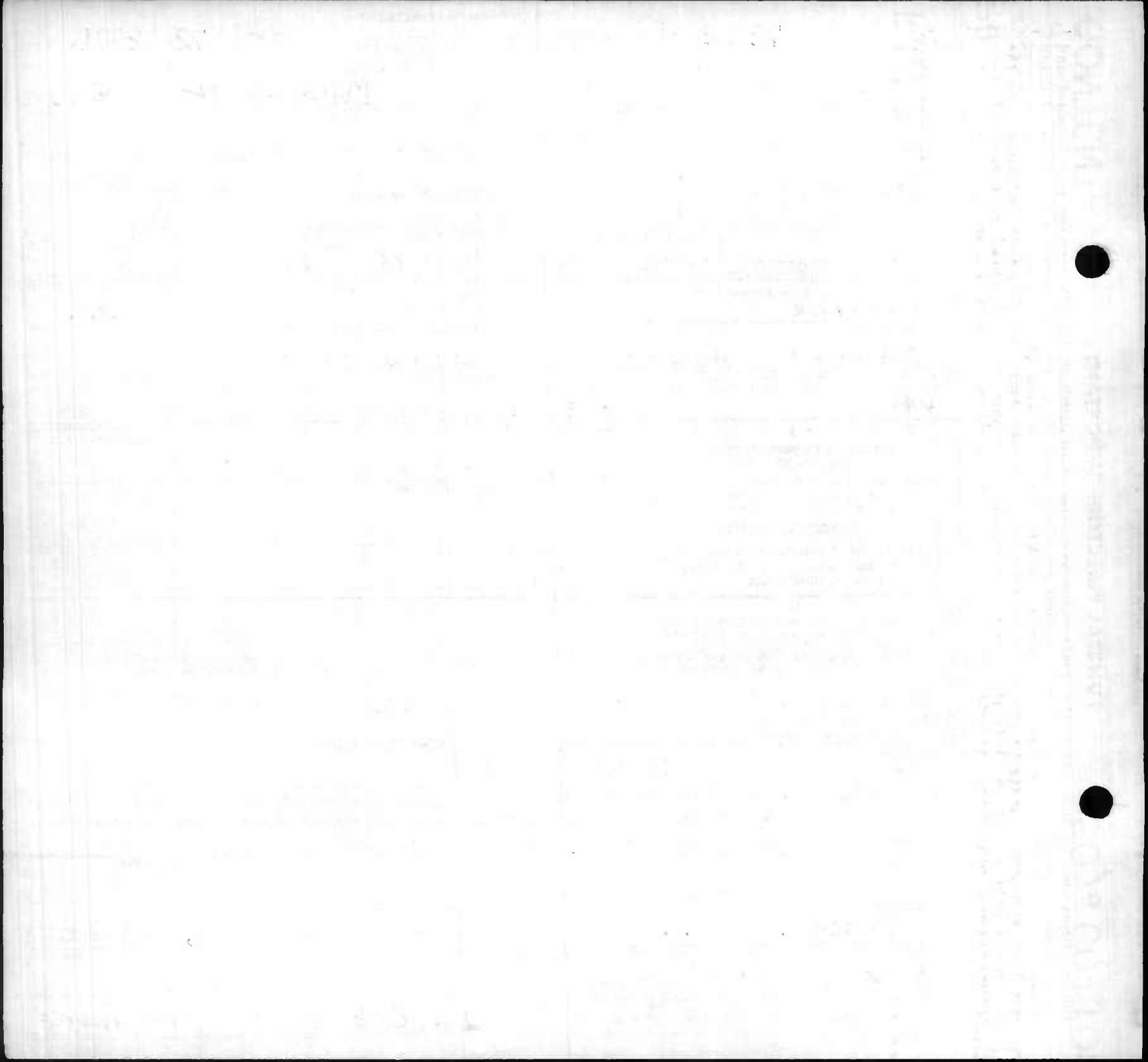
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-620 72 02960		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02960	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alice M. Dosch		3-22-1972 9.15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
31 Baltimore City Hospitals 4940 Eastern Avenue 21224 Baltimore, Maryland			Maryland 2611		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3129 Fait Avenue 21224		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 Yr. Months Days
Female	Caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-4-1903	68	11. BIRTHPLACE (State or foreign country)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
H.W.			New Jersey		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN OWENS			?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		214-01-4572		Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cardio-respiratory arrest 12 hrs		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) POSS Myocardial Infarction		
			(C) Arteriosclerotic Cardiovascular		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			None Known.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/21/72 19 to 3/22/72 19 that (I) (we) last saw the deceased alive on 3/22/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ronald A. Griffin M.D.				3/22/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Ronald A. Griffin M.D.				Baltimore City Hosp. East Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		3/25/72		SACRED HEART	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
BALTO. MD.		MAR 24 1972		J.G. CONNELLY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				300 MACE	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. A-352		72 02961		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02961	
1. NAME OF DECEASED (Type or Print) Mr. ADAMS JOSEPH				2. DATE AND HOUR OF DEATH March 23rd 1972 8 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 1940 Eastern Avenue Baltimore, Maryland 21224		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY Baltimore	
C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 179 Carroll Island Road		21221	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/08	9. AGE (in years last birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOTTLER			10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL ADAMS				14. MOTHER'S MAIDEN NAME ANNA CRUMY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 214-165309		17. INFORMANT BCH: RECORDS		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 736.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MULTIPLE CEREBROVASCULAR				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Accidents			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (old) Myocardial Infarction							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-17-1971 to 3-23-1972 that (I) (we) last saw the deceased alive on 3-21-1972 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Prakash G. Sane, M.D.				23B. DATE SIGNED 3-23-72			
23C. PHYSICIAN'S NAME (Type) Prakash G. Sane, M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3/24/72		24C. NAME of CEMETERY or CREMATORY LEODOR PARK		24D. LOCATION (City, town, or county) (State) BALTO-MD.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR J.G. BOWNELLY		ADDRESS 300 MACE	



B-620

72 02962

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 02962

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) THELMA MAE LEU BROOKS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 840 W. 34th Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 21, 1972 4:25 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-21-1904		10. AGE (In years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 412-41-2509	
18. INFORMANT Joseph A. Kilmon		ADDRESS 3134 Chestnut Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) no	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25, 1972	
24C. NAME of CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Frank H. Leitz	
25C. FUNERAL DIRECTOR 814 N 36th St		ADDRESS	

CONFIDENTIAL

WILLIAM L. BROWN

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		REG. NO. 72 02963	
E-645 BIRTH NO. 72 02963		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) William A. Erline		2. DATE AND HOUR OF DEATH March 21, 1972 5:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1202 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 300 E. 30th Street	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1883
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exterminator		9B. KIND OF BUSINESS OR INDUSTRY Pest Control	9C. AGE (In years last birthday) 88
10. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA	
12. FATHER'S NAME John Erline		13. MOTHER'S MAIDEN NAME Mary Zimmerman	
14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		15. SOCIAL SECURITY NO. 215-09-9772	
16. INFORMANT Mrs. Rachel Moore		17. ADDRESS 727 Melville Avenue	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 402X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 3/7/69 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (the hospital) attended the deceased from 3/7/69 to 1/9/71 , that (I) (we) last saw the deceased alive on 1/9/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE John A. O'Connor M.D. DEGREE 23B. DATE SIGNED March 23, 1972 23C. PHYSICIAN'S NAME (Type) John A. O'Connor M.D. 23D. ADDRESS 2701 St. Paul Street Baltimore Maryland 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 3/25/72 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore Maryland 25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972 25B. NAME OF REGISTRAR Leonard J. Buck Inc. 25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. 21214			

— 30 —

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>72 02964</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 72 02964</p>	
<p>BIRTH NO. D-450</p>		<p>2. DATE AND HOUR OF DEATH March 20, 1972 1 5:40 A.M.</p>	
<p>1. NAME OF DECEASED (Type or Print) DOLAN, James T.</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1102</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Ctr.</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1015 Cathedral Street</p>	
<p>5. SEX M</p>	<p>6. RACE N</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 9-17-97 9. AGE (in years last birthday) 74</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Engineer</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>11. BIRTHPLACE (State or foreign country) Pennsylvania</p>
<p>13. FATHER'S NAME UNKNOWN Thomas Dolan</p>		<p>14. MOTHER'S MAIDEN NAME Unknown Elizabeth Reed</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. 216-03-2393</p>	<p>17. INFORMANT Admission Record</p>
<p>18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE CA / lung DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 wks</p>	
<p>19A. DATE OF OPERATION 3/15/72</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 3/15 19 72 to 3/20 19 72 that (I) (we) last saw the deceased alive on 3/20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE ALAN H MARR</p>		<p>23B. DATE SIGNED 3/20/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) ALAN H MARR</p>		<p>23D. ADDRESS 26 Red St Reed</p>	
<p>24A. BURIAL CREMATION REMOVAL (Specify) Burial</p>	<p>24B. DATE 3-24-1972</p>	<p>24C. NAME OF CEMETERY or CREMATORY Lorraine Park</p>	<p>24D. LOCATION (City, town, or county) (State) Woodlawn Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972</p>		<p>25B. NAME OF REGISTRAR Reed</p>	
<p>25C. FUNERAL DIRECTOR Reed</p>		<p>ADDRESS 377 W North Ave</p>	

2013 51

2013 51

17 4

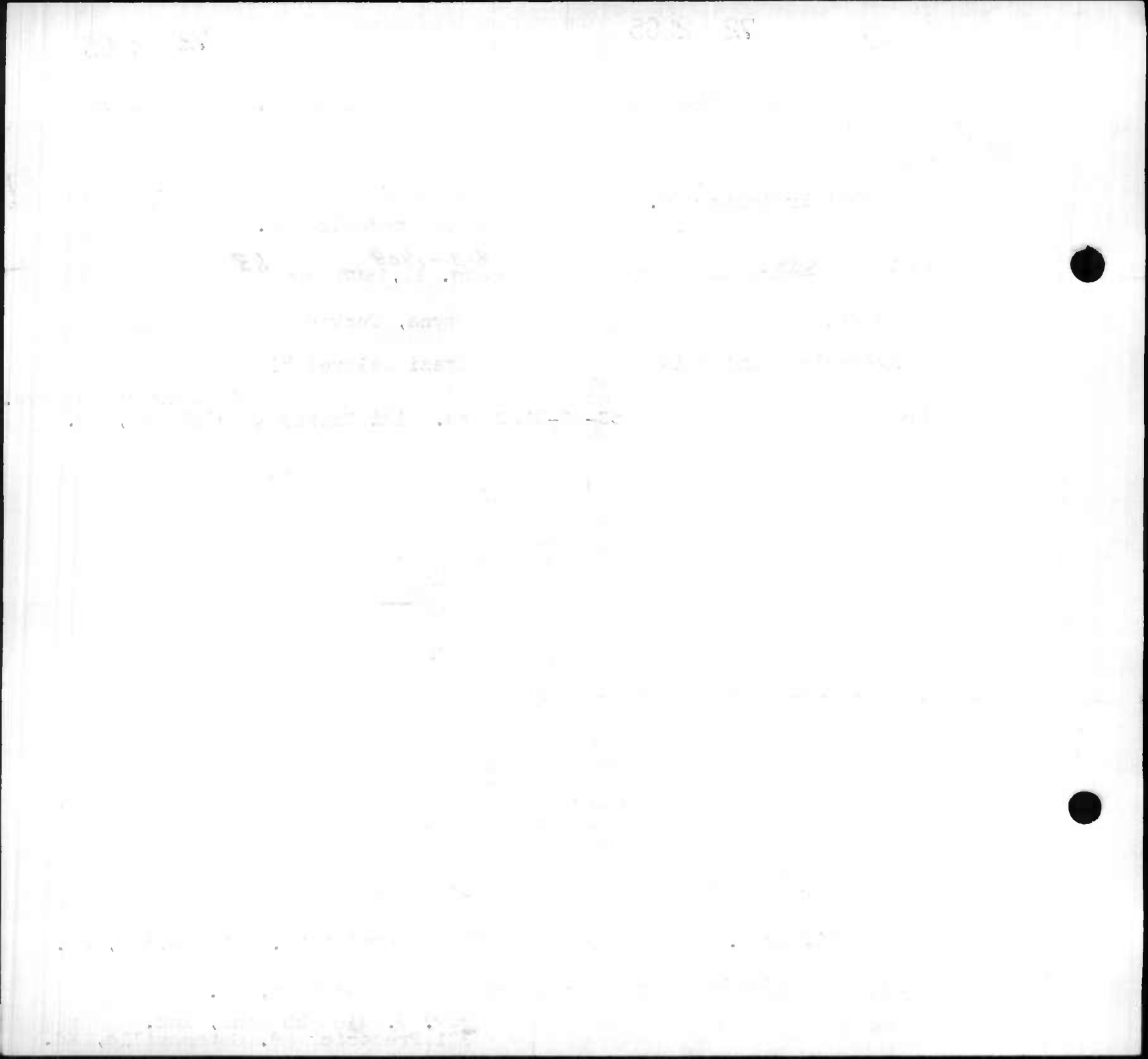
47 21

7-11



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
ESTHER MICHAELS		MARCH 19, 1972 10:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 4901 Frederick Rd.		Maryland BALTO 5300	
5. SEX		6. RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8-11-1908	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	
Housewife		63 63	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Home		Smyrna, Turkey	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Constantine Minadakis		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		253-52-3532	
17. INFORMANT		ADDRESS	
Mrs. Kiki Tsirigos		4901 Frederick Ave. Baltimore, Md.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		1 mo.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		Congested heart failure	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive A.D.C.V.D.	
II		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-11-1942 to 3-19-1972 that (I) (we) last saw the deceased alive on 3-13-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Wilmer K. Gallagher M.D.		3-20-72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Wilmer K. Gallagher M.D.		6209 Frederick Rd. Catonsville, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		3/22/72	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Greek Orthodox		Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
MAR 24 1972		Edw. S. MacNabb Sons, Inc.	
25C. FUNERAL DIRECTOR		ADDRESS	
301 Frederick Rd. Catonsville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02966	
E-146 BIRTH NO.				72 02966 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Henry Eppler				2. DATE AND HOUR OF DEATH 3-20-72 7 ³⁵ PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 The Good Samaritan Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 602 W. 36th St., 1307 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore, 21211 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER	
5. SEX Male	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/91	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10B. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown			
14. MOTHER'S MAIDEN NAME unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO. 212-10-2433		17. INFORMANT Patient			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 5 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED unknown		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 3-18-19 72 to 3-20-19 72 that (I) (we) last saw the deceased alive on 3-20-19 72 and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard Blum				23B. DATE SIGNED 3/20/72	
23C. PHYSICIAN'S NAME (Type) Bernard Blum				23D. ADDRESS 1520 36th street Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/24/72		24C. NAME OF CEMETERY or CREMATORY LOMAINE PARK	
24D. LOCATION (City, town, or county) BALTO. MD.		24E. ADDRESS			
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert J. [unclear]		25C. FUNERAL DIRECTOR [unclear] 3612 Chestnut Ave.	

50 S. 50

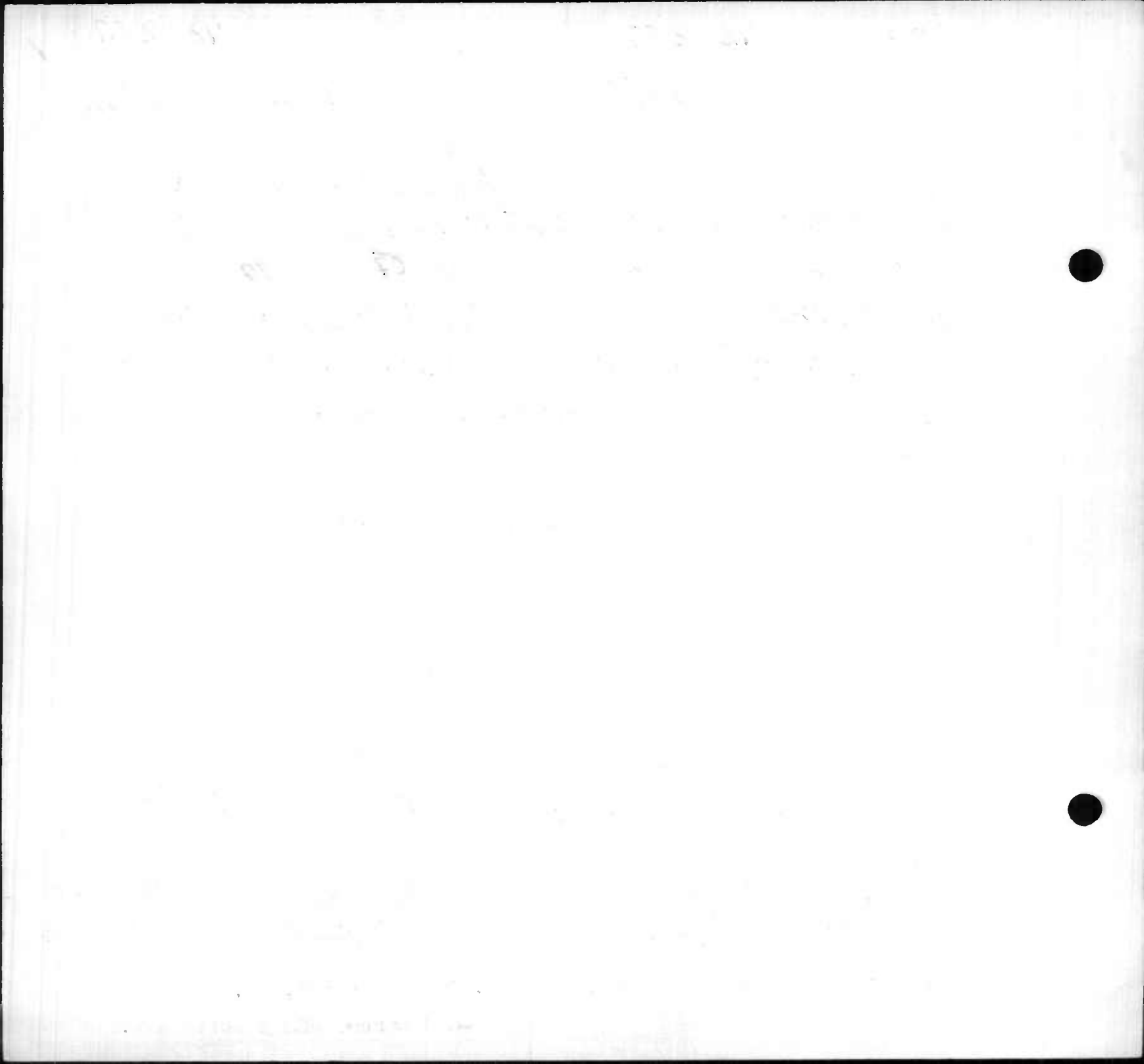
50 S. 50



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

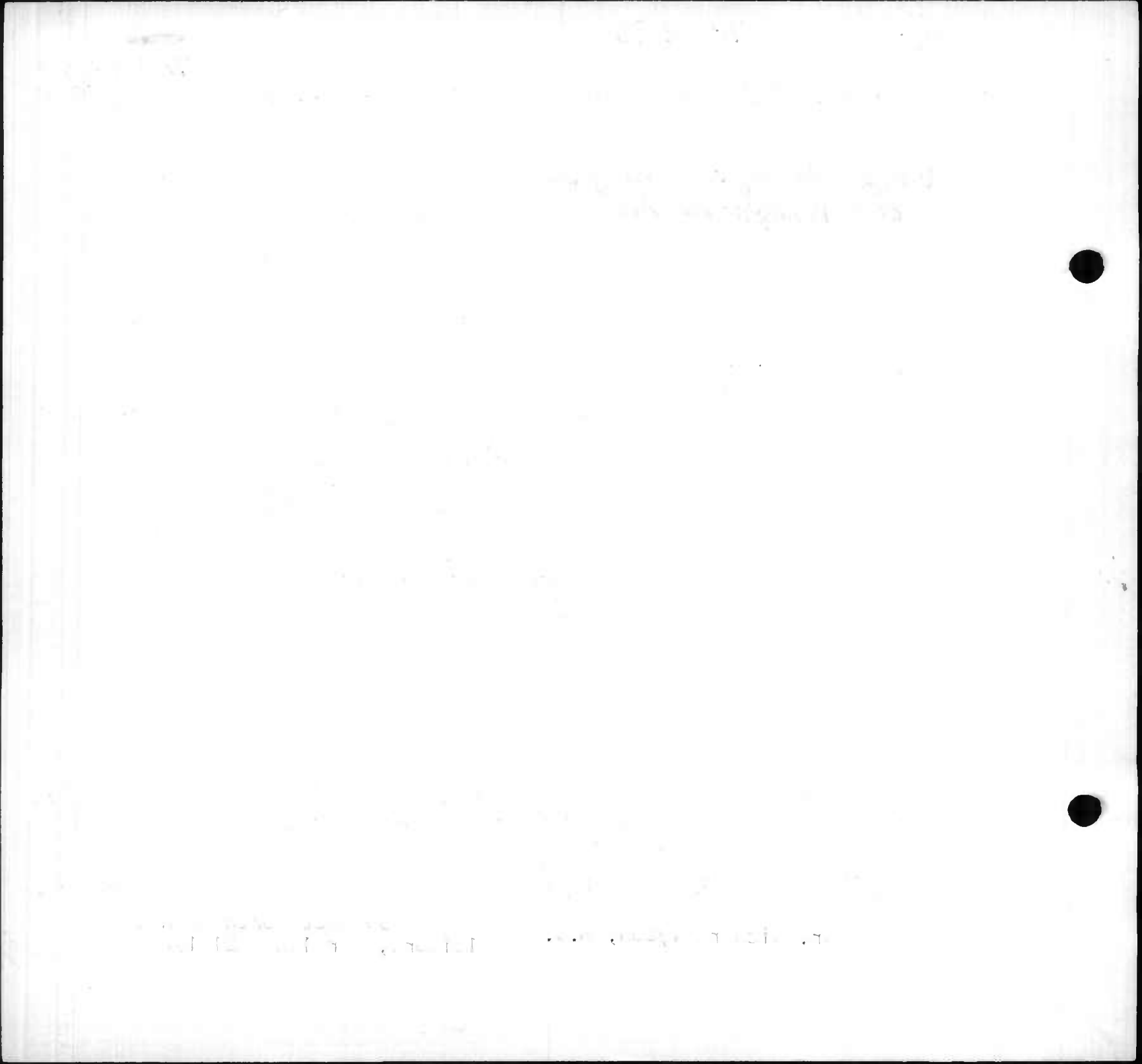
B-653		72 02967		BALTIMORE CITY HEALTH DEPARTMENT		72 02967	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LILLIE BRYANT		2. DATE AND HOUR OF DEATH 3-24-72 8:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hilton Nursing Home 1333 Poplar St				C. CITY OR TOWN BALTIMORE 21213		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1906 N. WASHINGTON STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-02	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIE (DROWN) DRAUGHN				14. MOTHER'S MAIDEN NAME MOLLY (JONES) KNIGHT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-206501A		17. INFORMANT ADDRESS LOUISE SMITH 1902 N. WASHINGTON ST			
18. 174X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH CARCINOMA OF BREAST I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. WITH METASTASIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/12/71 19 to 3/24/72 19 that (I) (we) last saw the deceased alive on 3/4/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harris JENNARD				23B. DATE SIGNED 3/24/72		23C. PHYSICIAN'S NAME (Type) Harris JENNARD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-28-72		24C. NAME OF CEMETERY or CREMATORY Md National Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR RECEIVED		25C. FUNERAL DIRECTOR ADDRESS Am C March 928 E North Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 111
BIRTH NO. <div style="font-size: 1.5em; font-weight: bold;">M-262</div> <div style="font-size: 1.5em; font-weight: bold;">72 02968</div>		DATE AND HOUR OF DEATH <div style="font-size: 1.5em; font-weight: bold;">3-23-72</div> <div style="font-size: 1.5em; font-weight: bold;">8:35 P.M.</div>		
1. NAME OF DECEASED (Type or Print) <div style="font-size: 1.2em;">(McCracklin) Georgia McCracken</div>		2. DATE AND HOUR OF DEATH <div style="font-size: 1.2em;">3-23-72</div> <div style="font-size: 1.2em;">8:35 P.M.</div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.2em;">George Washington Nursing Home 607 Pennsylvania Ave</div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore B. COUNTY Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="font-size: 1.2em;">4712 Pilgrim Rd</div>		
5. SEX <div style="font-size: 1.2em;">Female</div>	6. RACE <div style="font-size: 1.2em;">Black</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="font-size: 1.2em;">7-20-1911</div>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">Unknown</div>		10B. KIND OF BUSINESS OR INDUSTRY 		9. AGE (in years last birthday) <div style="font-size: 1.2em;">60</div>
11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">GA. U.S.A.</div>		12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.2em;">U.S.A.</div>		
13. FATHER'S NAME <div style="font-size: 1.2em;">Charles Hodges</div>		14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">Willie Bennett</div>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">215-18-9188</div>		17. INFORMANT <div style="font-size: 1.2em;">Hazel Chentshaw</div>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="font-size: 1.5em; font-weight: bold;">412.71</div>		CAUSE OF DEATH <div style="font-size: 1.5em; font-weight: bold;">Cerebral Epilepsy</div> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">Hypertensive Arteriosclerosis</div> (B) DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">Heart Disease</div> (C) DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em;">Left Hemiplegia</div>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <div style="font-size: 1.2em;">28 Jan 72</div> to <div style="font-size: 1.2em;">23 Mar 72</div> that (1) (we) last saw the deceased alive on <div style="font-size: 1.2em;">6 March 72</div> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <div style="font-size: 1.2em;">Richard Tyson, M.D.</div>				23B. DATE SIGNED <div style="font-size: 1.2em;">23 Mar 72</div>
23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Dr. Richard Tyson, M.D.</div>		23D. ADDRESS <div style="font-size: 1.2em;">936 West North Avenue Baltimore, Maryland 21217</div>		
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">Burial</div>		24B. DATE <div style="font-size: 1.2em;">3-28-72</div>		24C. NAME OF CEMETERY OR CREMATORY <div style="font-size: 1.2em;">Mt. Calvary Cemetery</div>
24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">Anne Arundel City, Md.</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em;">MAR 24 1972</div>		
25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR <div style="font-size: 1.2em;">Wm E MARCH 928 E NORTH AVE</div>		

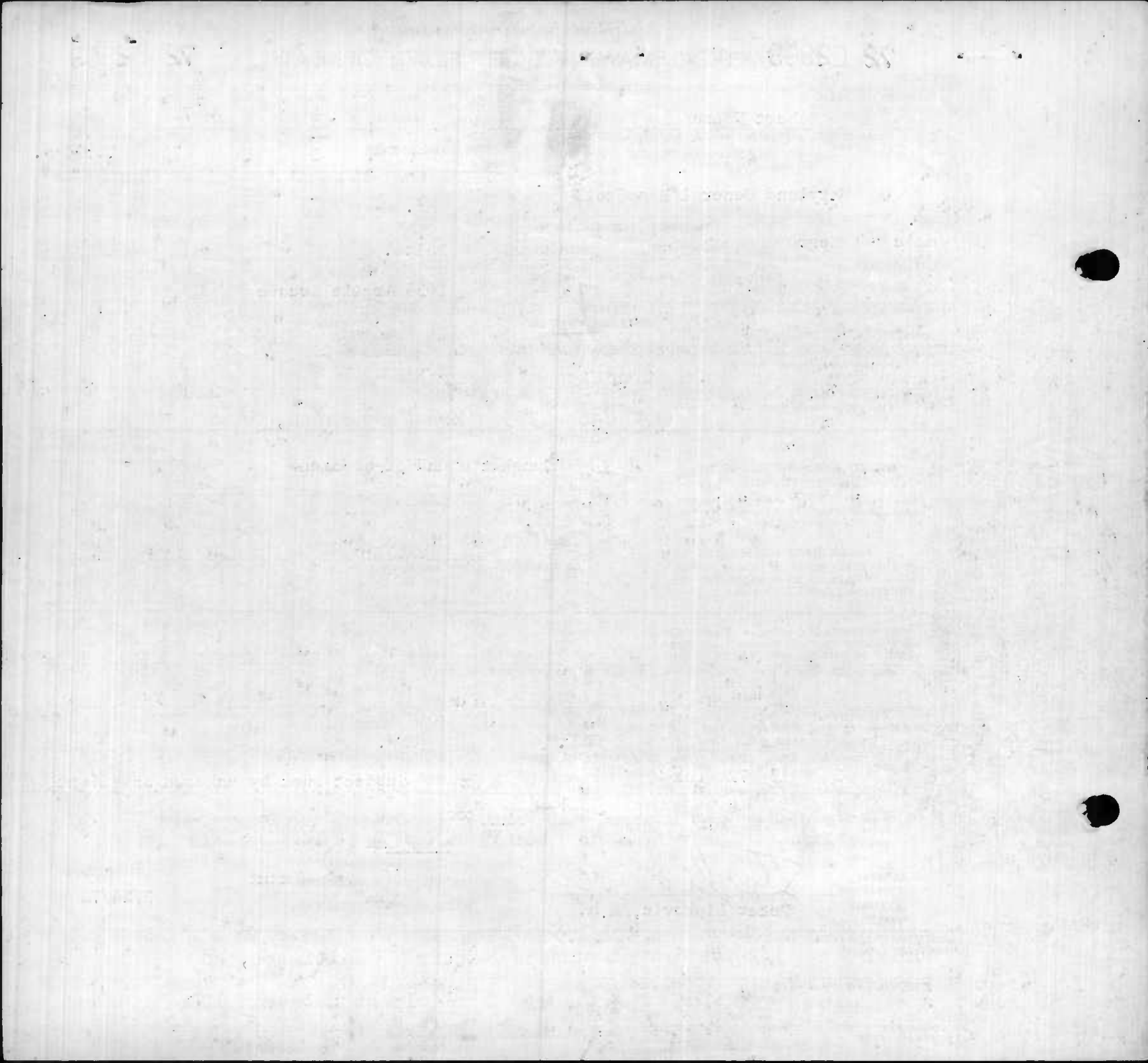


72 02969 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02969

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Hanna				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 3 Day 24 Year 72 Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital				3. DATE PRONOUNCED DEAD Month 3 Day 24 Year 72 Hour 12:40 a. M.			
6. SEX male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/6/26		10. AGE (In years lost birth day) 45		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY Construction		15. MOTHER'S MAIDEN NAME Martha	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. 248-64-4385		18. INFORMANT ADDRESS Mrs Mary Hanna, Same	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E9651X Gunshot wound of abdomen				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) UNK.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? UNK. 0000			
22D. TIME OF INJURY (APPROX.) 3 12 72 unk		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject shot by unknown assailant			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3/29/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR R. E. E. E. E. E.		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W north Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		72 02970		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02970	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JOHNSON, ELIZA			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 3/23/72 10-34 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2854 Butler Street			
5. SEX FEMALE	6. RACE NEGRO.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-05	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Joseph Butler				14. MOTHER'S MAIDEN NAME Ammy Mc Gowan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT James Johnson	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., if means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.	
				(B) Essential hypertension DUE TO, OR AS A CONSEQUENCE OF:		Several years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 3/21/72 19 to 3/23 1972 that (we) last saw the deceased alive on 3/23 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. L. Win				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) J. L. Win	
23D. ADDRESS LUTHERAN HOSPITAL				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. MAR 24 1972				25B. NAME OF REGISTRAR 2000		25C. FUNERAL DIRECTOR E. Wilson	
				25D. ADDRESS 1000 Prattley Ave.			

Joseph Butler

18

Amey McNamee

John McNamee

Printed

3-27-77 Mt. Vernon Co. N.Y.

Edw. O. R. Co.

54-57-42

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Carrie Bucher

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)31 Baltimore City Hospitals
4940 Eastern Avenue 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

2/21/91

9. AGE (In years
last birthday)

80

If Under 1 Yr.
Months Days Hours Min.

80

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

Isabelle

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

BCH-Records

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Atrial Fibrillation, LBBB

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____
that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Leon Landau

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

Leon Landau M.D.

DEGREE

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/25/72

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 24 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

OK

12/12/12

12/12/12

12/12/12

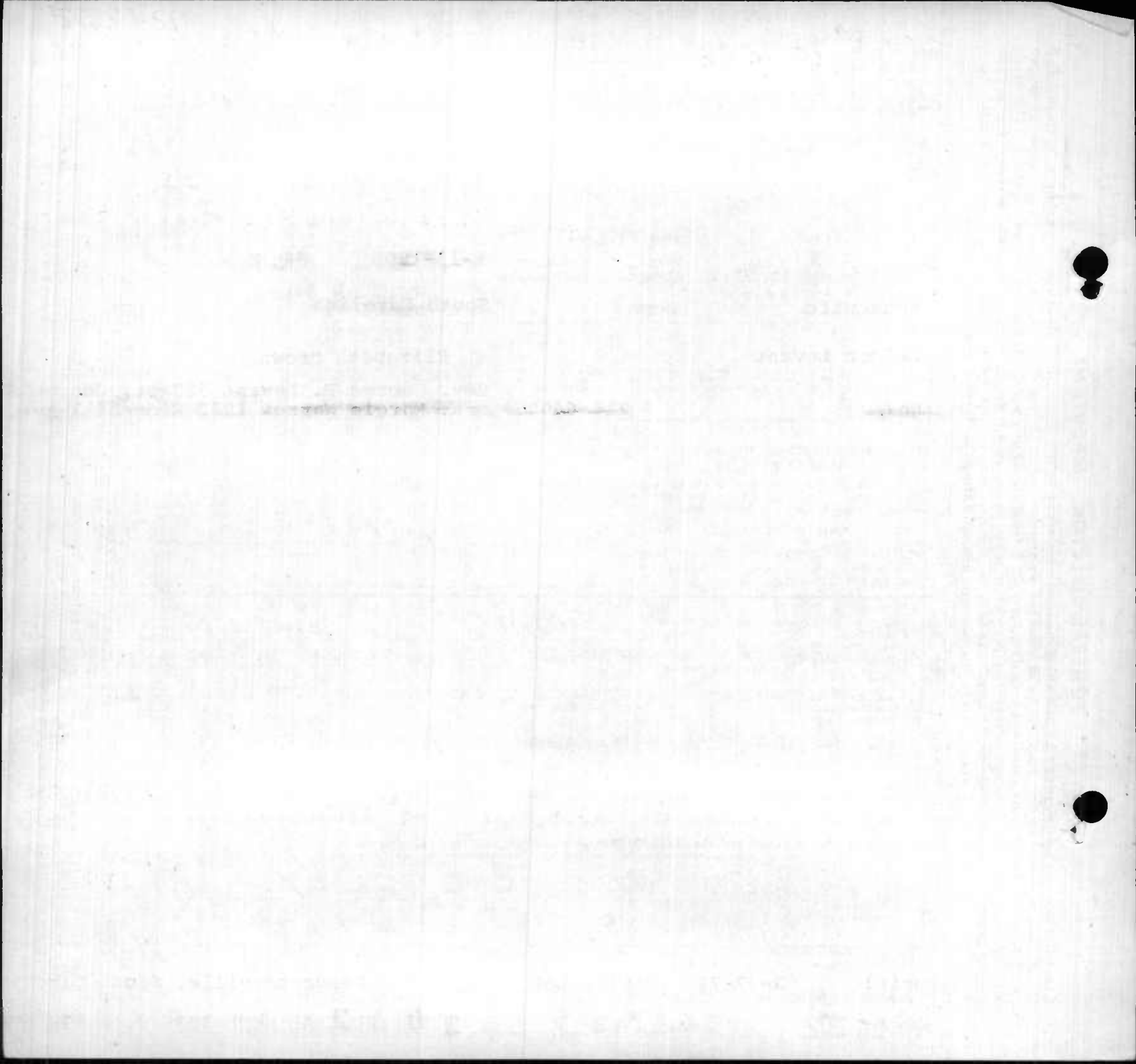
12/12/12

12/12/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02972	
7-626 72 02972				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRAZIER, NEATHER		2. DATE AND HOUR OF DEATH MARCH 22, 1972 1³⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1604		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION PAAR Hill Nursing Home 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-1905	9. AGE (In years) 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Nelson Levant		14. MOTHER'S MAIDEN NAME Elizabeth Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-640368		17. INFORMANT ADDRESS Rev. George E. Levant 523 St. George S Mrs. Margie Warren 1932 Ridgehill Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHF		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1d	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fractured - Cerebrum			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 Mon 1972 to 22 Mon 1972 , that (I) (we) last saw the deceased alive on 22 Mon 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Hulla MD				23B. DATE SIGNED 22 Mon 72	
23C. PHYSICIAN'S NAME (Type) J. Hulla M.D.				23D. ADDRESS 2214 E. Fayette 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-72		24C. NAME OF CEMETERY or CREMATORY Family Lot	
24D. LOCATION (City, town, or county) (State) Hendersonville, South Carolina		25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
25B. NAME OF REGISTRAR Robert E. J. ...		25C. FUNERAL DIRECTOR NUTTER			
25D. ADDRESS FUNERAL HOME 3035 W. NORTH AV					



H-520 72 02973

BALTIMORE CITY HEALTH DEPARTMENT

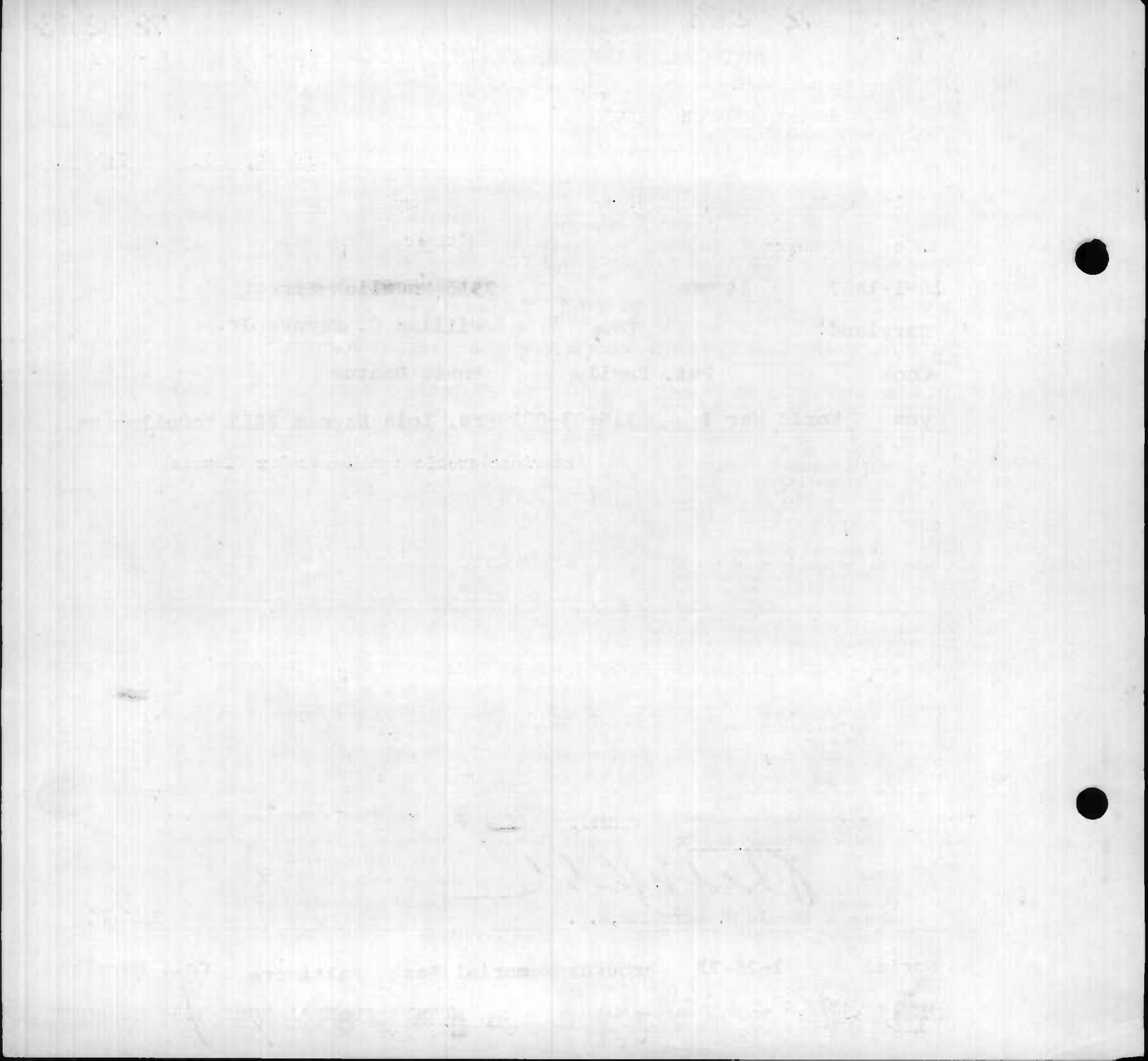
72 02973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM SHERMAN HAYNES				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2515 McCulloh Street, 2nd floor				3. DATE PRONOUNCED DEAD Month Day Year Hour March 22, 1972 7:10 A. M.			
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1303	
9. DATE OF BIRTH 10-1-1887		10. AGE (In years last birthday) 84		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. Haynes Jr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		15. MOTHER'S MAIDEN NAME Annie Bantum		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I	
17. SOCIAL SECURITY NO. 215-03-0229		18. INFORMANT Mrs. Lola Haynes		19. CAUSE OF DEATH 412.41 Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) _____			
20A. DATE OF OPERATION 3-25-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/22/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-72		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert C. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AV.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 02974</u>	
6-630 72 02974		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>VIRGINIA BRITT</u>		2. DATE AND HOUR OF DEATH <u>3-22-72</u> <u>2:05 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>909</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1729 AIKEN ST.</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1879</u>
9. AGE (In years last birthday) <u>92</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SIDNEY STONE</u>		14. MOTHER'S MAIDEN NAME <u>LUCY RICHARDSON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-9865</u>	
17. INFORMANT <u>MRS. MARY WATFORD</u>		ADDRESS <u>1729 AIKEN STREET</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD + Pol. Emboli</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic UTI's</u> <u>Atrial Fibrillation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 10</u> 19 <u>72</u> to <u>March 22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>March 22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>J. H. Varnell Jr.</u>		23B. DATE SIGNED <u>3/22/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. H. VARNELL JR. M.D.</u>		23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-27-72</u>	
24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Walter E. J. J. J.</u>	
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>		ADDRESS <u>3035 W. NORTH AVE</u>	

1-28-71

YOU

1-28-71

1-28-71

W-300 72 02975

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02975

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. White Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 20, 1972 Hour 3:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour March 20, 1972 3:45 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1303			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 11-29-1888	10. AGE (In years last birthday) 83	E. STREET AND NUMBER 2319 Madison Avenue	
11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME James H. White	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		15. MOTHER'S MAIDEN NAME Martha Robinson	
14B. KIND OF BUSINESS OR INDUSTRY Public School			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	17. SOCIAL SECURITY NO. 214-40-8512	18. INFORMANT ADDRESS Mrs. Edith White 2319 Madison Avenue	
19. E 812.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia of left lung complicating (A) IMMEDIATE CAUSE multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Liberty Hgts. Ave. & Reisterstown Rd.	
22D. TIME OF INJURY (APPROX.) 3-10-72 12:50 P. M.	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Passenger in auto-truck collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 21, 1972 ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-25-1972	24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE	

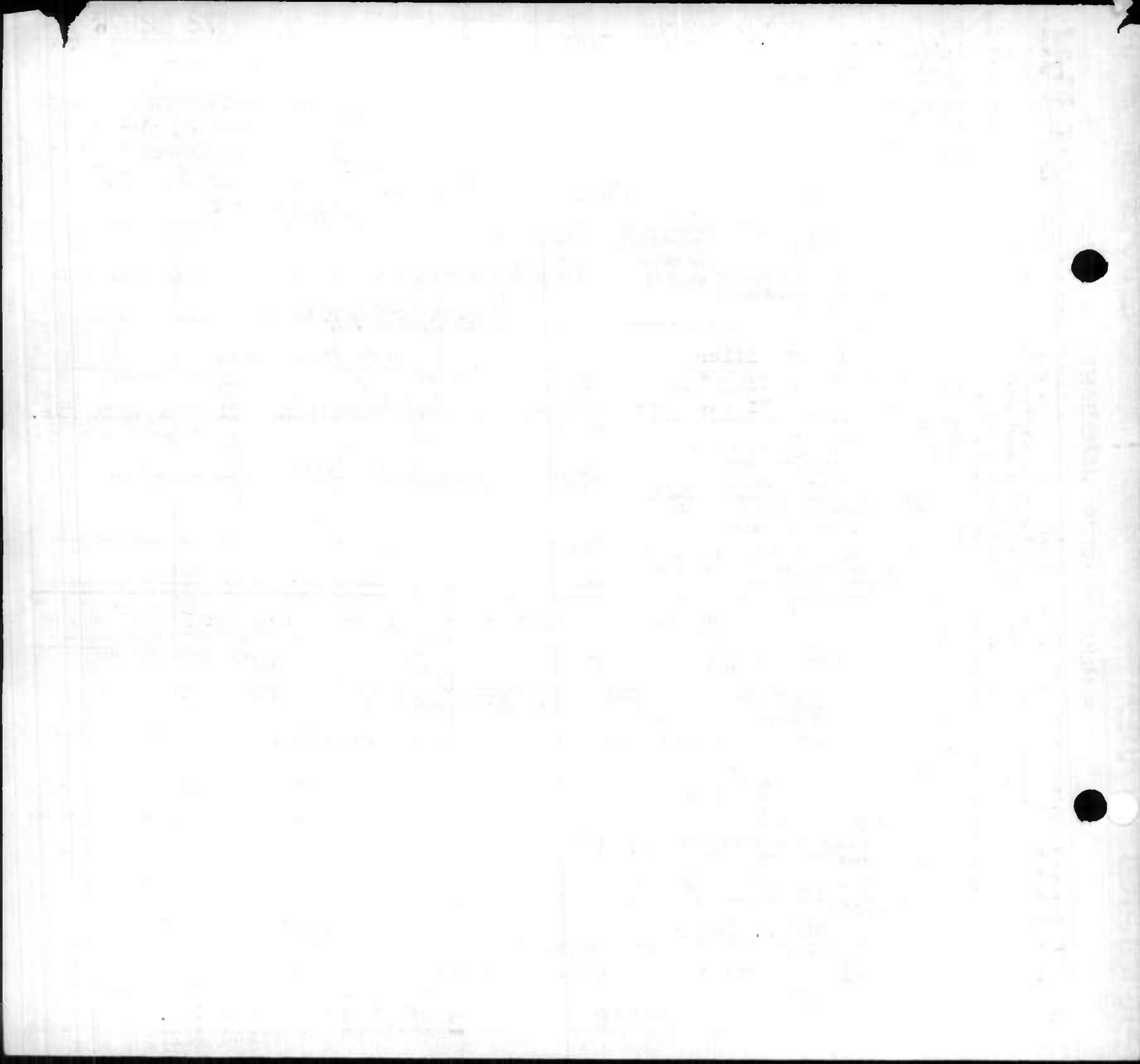
THE UNIVERSITY OF CHICAGO
CHICAGO, ILLINOIS
JANUARY 1, 1900
TO THE PRESIDENT OF THE UNIVERSITY
FROM THE FACULTY
SIR,
We have the honor to acknowledge the receipt of your letter of the 29th inst. in relation to the proposed changes in the curriculum of the University. We are glad to hear that you are so deeply interested in the subject, and we are sure that your suggestions will be most valuable to the University. We are sure that the Faculty will be able to make the necessary changes in the curriculum, and we are sure that the University will be able to maintain its high standard of excellence.

VALLEY PAPER CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

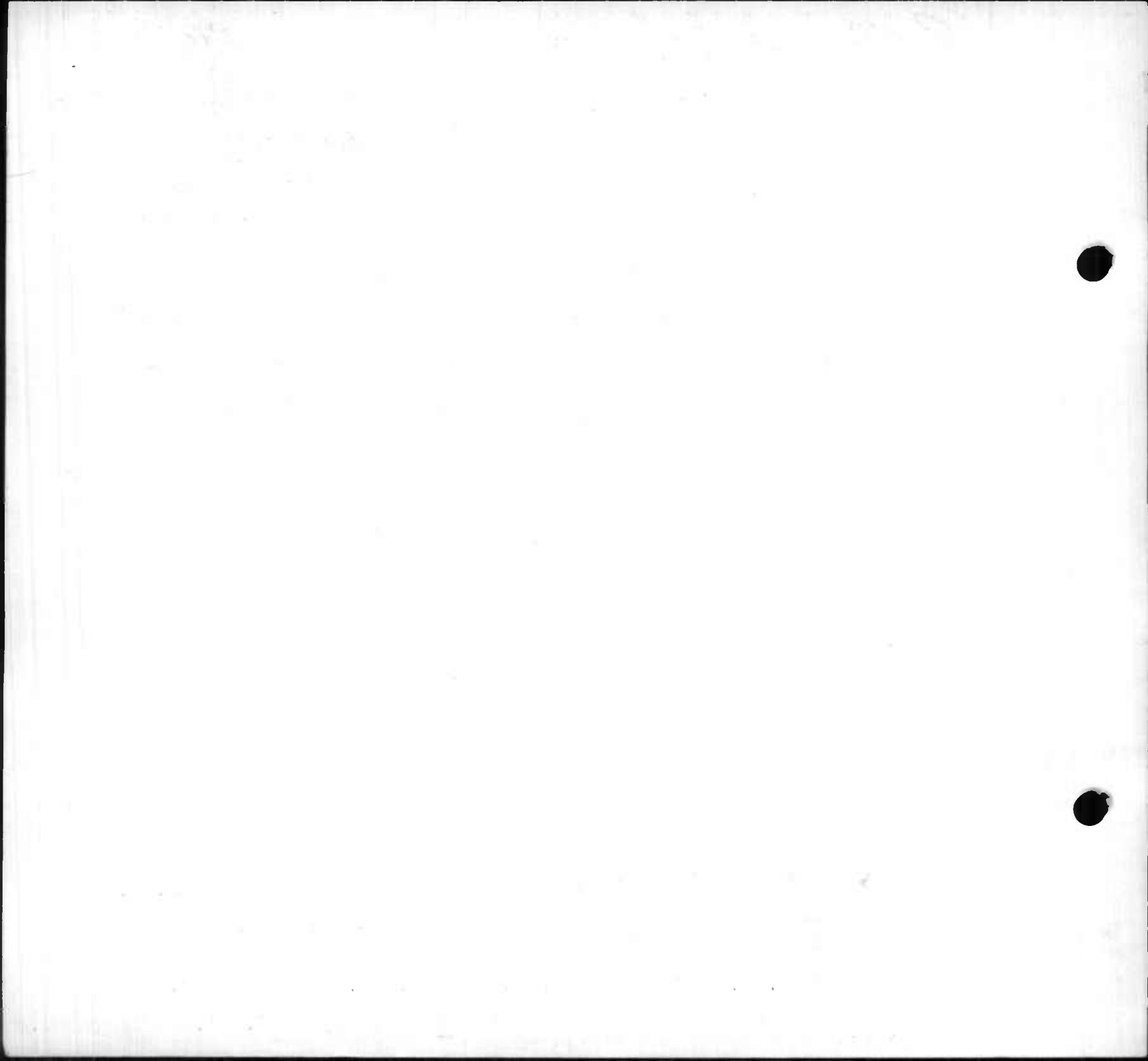
M-460		72 02976		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02976	
1. NAME OF DECEASED (Type or Print) VIOLET MILLER				2. DATE AND HOUR OF DEATH 3/23/72 1245 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) +4 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 908			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1021 BONAPARTE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/2/91	9. AGE in years (last birthday) 81	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Albert Miller			
14. MOTHER'S MAIDEN NAME Mary Anna Braun				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 212 60 4026				17. INFORMANT Mrs Audrey Wilson			
18. 486 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGESTIVE HEART FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CONGESTIVE HEART FAILURE				20. DATE OF OPERATION 0			
21. CONDITION FOR WHICH OPERATION WAS PERFORMED				22. AUTOPSY? (Yes or No) NO		23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. TIME OF INJURY (APPROX) 1 Month () Day () Year () Hour ()				28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/23 1972 to 3/23 1972 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Anne L. Leddy M.D.			
23B. DATE SIGNED 3/23/72				23C. PHYSICIAN'S NAME (Type) Anne L. Leddy			
23D. ADDRESS Union Memorial Hospital.				23E. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23F. NAME OF REGISTRAR John E. Sander				23G. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23H. ADDRESS Baltimore Maryland 21213				23I. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23J. NAME OF REGISTRAR John E. Sander				23K. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23L. ADDRESS Baltimore Maryland 21213				23M. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23N. NAME OF REGISTRAR John E. Sander				23O. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23P. ADDRESS Baltimore Maryland 21213				23Q. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23R. NAME OF REGISTRAR John E. Sander				23S. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23T. ADDRESS Baltimore Maryland 21213				23U. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23V. NAME OF REGISTRAR John E. Sander				23W. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23X. ADDRESS Baltimore Maryland 21213				23Y. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23Z. NAME OF REGISTRAR John E. Sander				23AA. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AB. ADDRESS Baltimore Maryland 21213				23AC. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23AD. NAME OF REGISTRAR John E. Sander				23AE. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AF. ADDRESS Baltimore Maryland 21213				23AG. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23AH. NAME OF REGISTRAR John E. Sander				23AI. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AJ. ADDRESS Baltimore Maryland 21213				23AK. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23AL. NAME OF REGISTRAR John E. Sander				23AM. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AN. ADDRESS Baltimore Maryland 21213				23AO. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23AP. NAME OF REGISTRAR John E. Sander				23AQ. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AR. ADDRESS Baltimore Maryland 21213				23AS. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23AT. NAME OF REGISTRAR John E. Sander				23AU. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AV. ADDRESS Baltimore Maryland 21213				23AW. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23AX. NAME OF REGISTRAR John E. Sander				23AY. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23AZ. ADDRESS Baltimore Maryland 21213				23BA. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BB. NAME OF REGISTRAR John E. Sander				23BC. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23BD. ADDRESS Baltimore Maryland 21213				23BE. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BF. NAME OF REGISTRAR John E. Sander				23BG. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23BH. ADDRESS Baltimore Maryland 21213				23BI. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BJ. NAME OF REGISTRAR John E. Sander				23BK. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23BL. ADDRESS Baltimore Maryland 21213				23BM. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BN. NAME OF REGISTRAR John E. Sander				23BO. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23BP. ADDRESS Baltimore Maryland 21213				23BQ. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BR. NAME OF REGISTRAR John E. Sander				23BS. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23BT. ADDRESS Baltimore Maryland 21213				23BU. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BV. NAME OF REGISTRAR John E. Sander				23BW. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23BX. ADDRESS Baltimore Maryland 21213				23BY. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23BZ. NAME OF REGISTRAR John E. Sander				23CA. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CB. ADDRESS Baltimore Maryland 21213				23CC. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CD. NAME OF REGISTRAR John E. Sander				23CE. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CF. ADDRESS Baltimore Maryland 21213				23CG. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CH. NAME OF REGISTRAR John E. Sander				23CI. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CJ. ADDRESS Baltimore Maryland 21213				23CK. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CL. NAME OF REGISTRAR John E. Sander				23CM. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CN. ADDRESS Baltimore Maryland 21213				23CO. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CP. NAME OF REGISTRAR John E. Sander				23CQ. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CR. ADDRESS Baltimore Maryland 21213				23CS. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CT. NAME OF REGISTRAR John E. Sander				23CC. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CU. ADDRESS Baltimore Maryland 21213				23CD. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CV. NAME OF REGISTRAR John E. Sander				23CE. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CW. ADDRESS Baltimore Maryland 21213				23CF. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CX. NAME OF REGISTRAR John E. Sander				23CG. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23CY. ADDRESS Baltimore Maryland 21213				23CH. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23CZ. NAME OF REGISTRAR John E. Sander				23CI. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DA. ADDRESS Baltimore Maryland 21213				23CJ. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DB. NAME OF REGISTRAR John E. Sander				23CK. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DC. ADDRESS Baltimore Maryland 21213				23CL. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DD. NAME OF REGISTRAR John E. Sander				23CM. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DE. ADDRESS Baltimore Maryland 21213				23CN. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DE. NAME OF REGISTRAR John E. Sander				23CO. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DF. ADDRESS Baltimore Maryland 21213				23CP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DF. NAME OF REGISTRAR John E. Sander				23CQ. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DG. ADDRESS Baltimore Maryland 21213				23CR. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DG. NAME OF REGISTRAR John E. Sander				23CS. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DH. ADDRESS Baltimore Maryland 21213				23CT. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DH. NAME OF REGISTRAR John E. Sander				23CU. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DI. ADDRESS Baltimore Maryland 21213				23CV. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DI. NAME OF REGISTRAR John E. Sander				23CW. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DJ. ADDRESS Baltimore Maryland 21213				23CX. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DJ. NAME OF REGISTRAR John E. Sander				23CY. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DK. ADDRESS Baltimore Maryland 21213				23CZ. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DK. NAME OF REGISTRAR John E. Sander				23DA. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DL. ADDRESS Baltimore Maryland 21213				23DB. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DL. NAME OF REGISTRAR John E. Sander				23DC. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DM. ADDRESS Baltimore Maryland 21213				23DD. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DM. NAME OF REGISTRAR John E. Sander				23DE. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DN. ADDRESS Baltimore Maryland 21213				23DE. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DN. NAME OF REGISTRAR John E. Sander				23DF. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DO. ADDRESS Baltimore Maryland 21213				23DF. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DO. NAME OF REGISTRAR John E. Sander				23DG. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DG. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DH. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DH. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DI. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DI. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DJ. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DJ. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DK. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DK. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DL. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DL. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DM. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DM. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DN. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DN. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DO. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DO. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore Maryland 21213				23DP. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
23DP. NAME OF REGISTRAR John E. Sander				23DP. FUNERAL DIRECTOR Henry Sander & Sons Inc.			
23DP. ADDRESS Baltimore							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

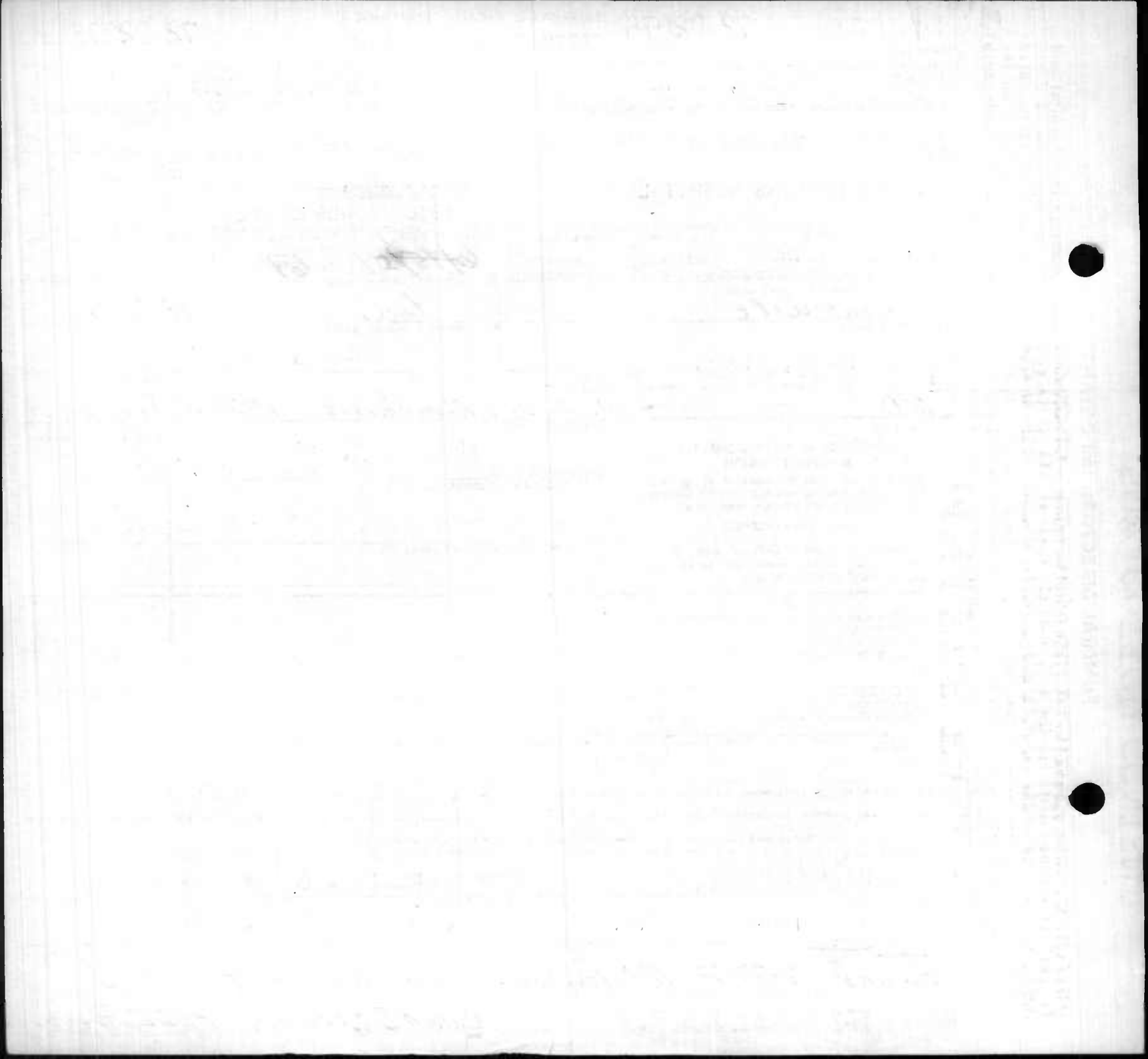
BALTIMORE CITY HEALTH DEPARTMENT				72 02977		REG. NO. 72 02977	
BIRTH NO. <div style="font-size: 2em; float: left; margin-right: 10px;">R-140</div> <div style="font-size: 2em; float: left;">72 02977</div>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CHARLOTTE M. ROBL</u>				2. DATE AND HOUR OF DEATH <u>3/24/72</u> <u>4:00</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>GOOD SAMARITAN HOSPITAL</u> <u>45</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2758</u> 5. CITY OR TOWN <u>BALTIMORE</u> 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER <u>1904 RAMBLEWOOD RD.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-19-95</u>	9. AGE (in years last birthday) <u>77</u>	10. UNDER 1 Yr. Months: <u> </u> Days: <u> </u> Hours: <u> </u> Min: <u> </u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Restaurantier-Retired</u>			
13. FATHER'S NAME <u>OTTO GRONERT</u>				14. MOTHER'S MAIDEN NAME <u>CHARLOTTE HOLMUSER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212322169</u>		17. INFORMANT <u>CHARLES GRONERT</u> ADDRESS	
18. CAUSE OF DEATH <u>154.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MULTIPLE MYELOMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CARCINOMA OF RECTUM</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>3 mo</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>3/4</u> <u>19 72</u> to <u>3/24</u> <u>19 72</u> that (I) (we) last saw the deceased alive on <u>3/24</u> <u>19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>E. Feinglass, MD.</u>				23B. DATE SIGNED <u>Mar. 25. 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD FEINGLASS</u>	
23D. ADDRESS <u>Johns Hopkins Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>March. 27. 1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Pk. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>	
25B. NAME OF REGISTRAR <u>Henry Sander</u>		25C. FUNERAL DIRECTOR <u>SONS, INC.</u>		ADDRESS <u>Baltimore Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

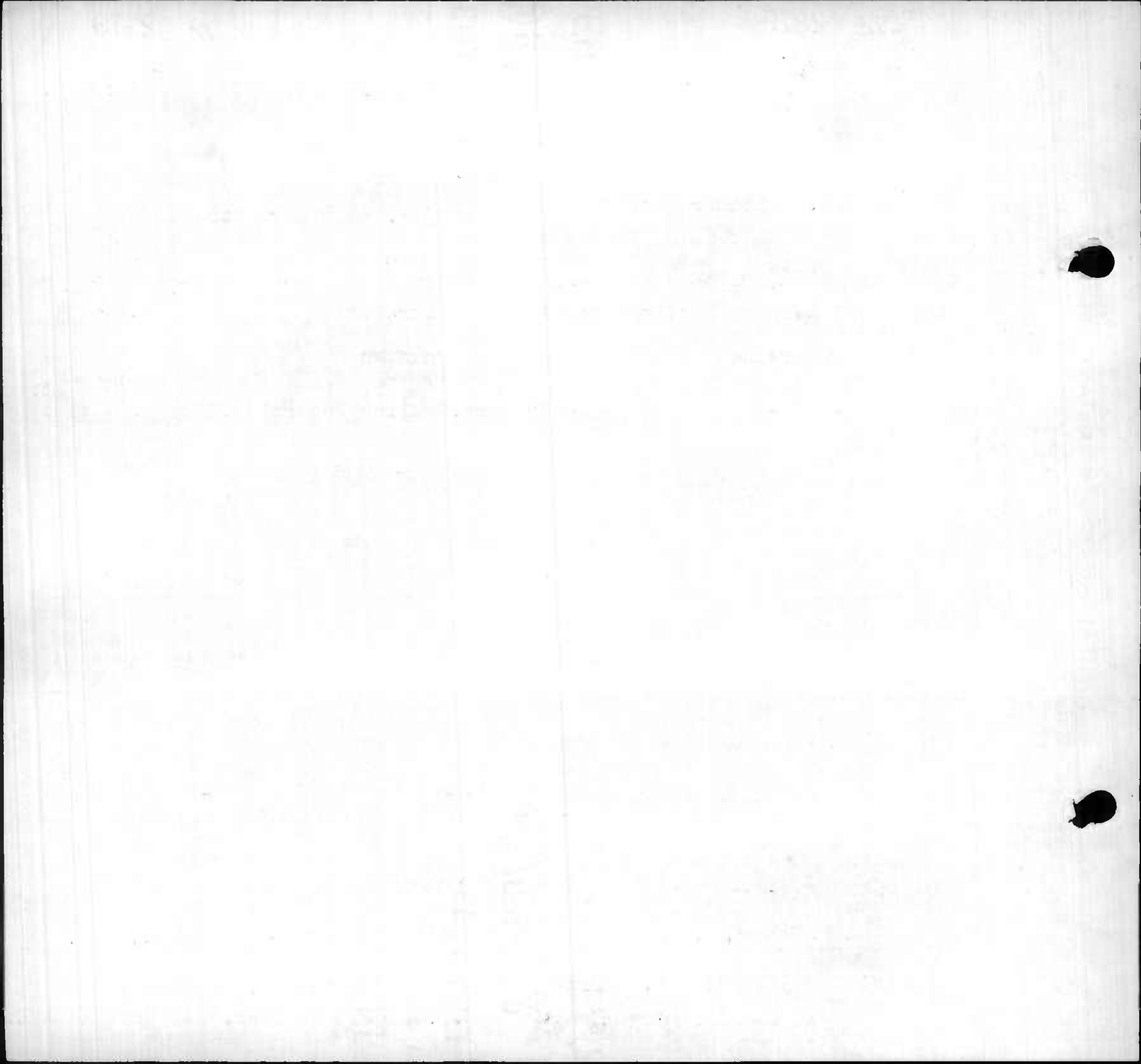
<div style="display: flex; justify-content: space-between;"> M-250 72 02978 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 72 02978 </div>			
1. NAME OF DECEASED <u>SPEIGHTS</u> (Type or Print) <u>MOUZON, EFFIE</u>		2. DATE AND HOUR OF DEATH <u>03/24/72 225PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>704</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1636 ASHLAND AVE</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/04</u>
9. AGE (In years, last birthday) <u>67</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SPEIGHTS, SIDNEY</u>		14. MOTHER'S MAIDEN NAME <u>ALLEN, LAVENIA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217 22 5193</u>	
17. INFORMANT <u>Alva Harris</u>		ADDRESS <u>1427 E. Preston St.</u>	
18. <u>188X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal shutdown, CHF</u> (B) <u>substantive transitory renal cell bladder</u> (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>3/24/72</u> 19__ to <u>3/24/72</u> 19__ that (I) <u>we</u> last saw the deceased alive on <u>3/24/72</u> 19__ and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.			
23A. SIGNATURE <u>Norman Daikoku</u> M.D.		23B. DATE SIGNED <u>3/24/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>NORMAN DAIKOKU</u> M.D.		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-27-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Westport Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Balwin B. Scruggs</u>	
25C. FUNERAL DIRECTOR ADDRESS <u>1412 E. Preston</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02979	
<div style="display: flex; justify-content: space-between;"> 72 02979 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROMAN POHORELOW			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH March 24, 1972 11:00 P. M.			
FULL NAME OF HOSPITAL OR INSTITUTION 00 2223 E. Baltimore Street		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 603			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/20/10		9. AGE (In years last birthday) 61		10. BIRTHPLACE (State or foreign country) Ukraine	
11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? Ukraine			
13. FATHER'S NAME Karpo Pohorelow		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 213-34-4268		17. INFORMANT Mrs. Pauline Pohorelow, 2223 E. Baltimore St.	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-5-72 19 72 to 3-4 19 72 , that (I) (we) last saw the deceased alive on 3-4 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. N. Rahman, M.D.</i> DEGREE				23B. DATE SIGNED 3/27/72	
23C. PHYSICIAN'S NAME (Type) A. N. Rahman, M. D. DEGREE				23D. ADDRESS 100 North Broadway Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/72		24C. NAME OF CEMETERY or CREMATORY St. Andrew	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR M. F. SADOWSKI & SONS, 1808 EASTERN AVE.		25C. FUNERAL DIRECTOR ADDRESS			



1
W 435

72 02980

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02980

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marvin Walden		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 25 72 4:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 25 72 4:00 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1503			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 6, 1952		10. AGE (In years last birthday) 19	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Russell Walden		14. MOTHER'S MAIDEN NAME Isabell Bolling	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Printer		16. KIND OF BUSINESS OR INDUSTRY Sign Co.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 212-58-5632	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E9881X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 3-2-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED craniotomy; evacuation of subdural hematoma	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) unknown	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? unknown			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour unknown		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? possibly fell striking head			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/29/72	
24C. NAME OF CEMETERY or CREMATORY Maryland National Cemetery		24D. LOCATION (City, town, or county) (State) Muirkirk Md.	
25A. DATE REC'D BY HEALTH DEPT APR 4 1972		25B. NAME OF REGISTRAR Joseph L. Russ, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Russ, 2222 W. North Ave.		ADDRESS	

15 8280

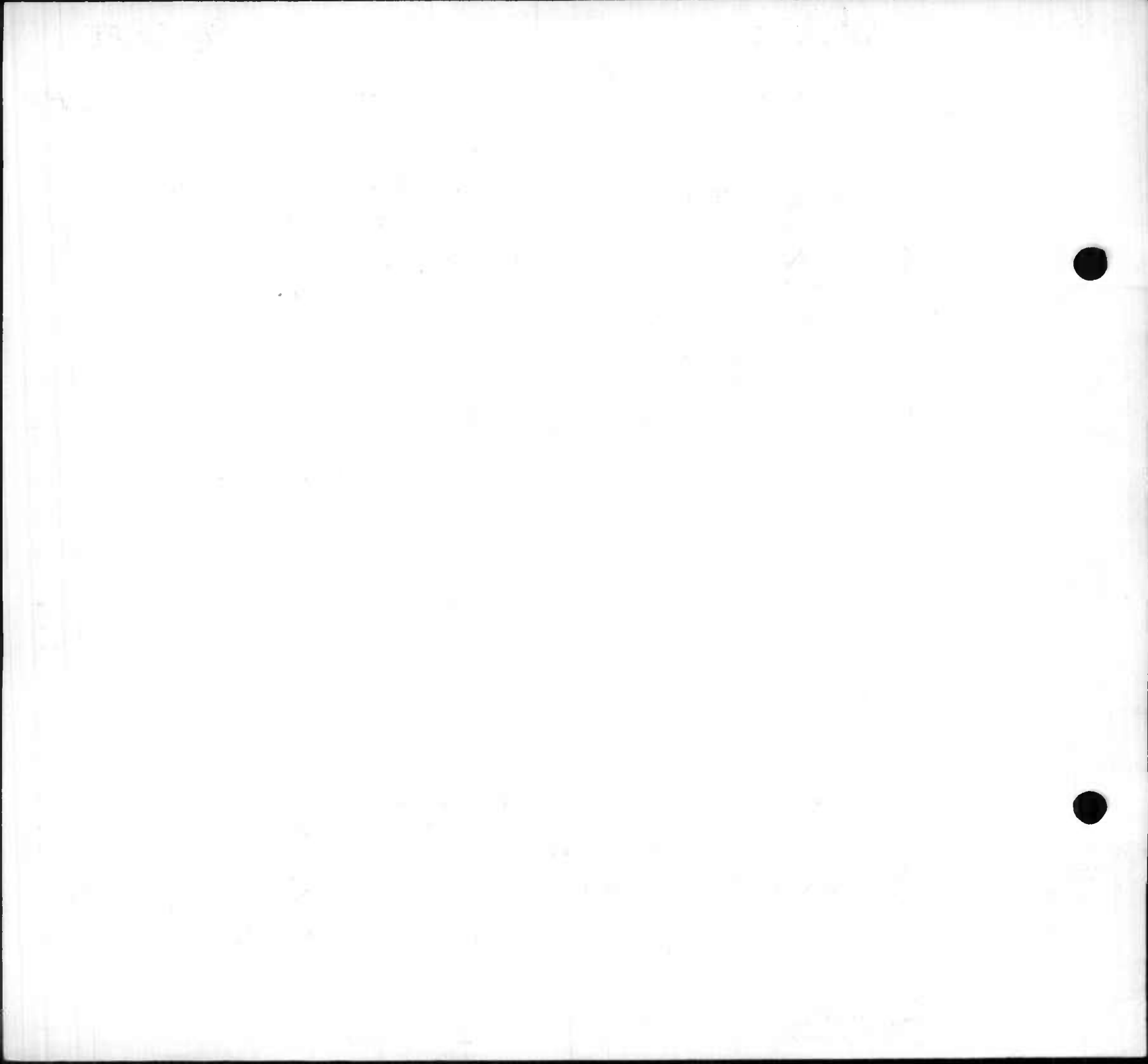
15 8280

RECEIVED BY BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 02981		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02981	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ethel Wonnell</u>		2. DATE AND HOUR OF DEATH <u>3/23/72</u> <u>4 15 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>501</u>		5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>211 Colvin St.</u>		8. DATE OF BIRTH <u>1/26/31</u>		9. AGE (In years last birthday) <u>41</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shot hand written school</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>school</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Wilson Cornish</u>		14. MOTHER'S MAIDEN NAME <u>Clara M. Arney</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-24-4132</u>		17. INFORMANT <u>HELENA HUNN</u> ADDRESS <u>3203 NORMOUNT</u>	
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Carcinoma of the Breast</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>3 years</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>March 23</u> 19 <u>72</u> to <u>March 23</u> 19 <u>72</u> that (2) (we) lost saw the deceased alive on <u>March 23</u> 19 <u>72</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>E. Mahaffey M.D.</u>		23B. DATE SIGNED <u>3/23/72</u>		23C. PHYSICIAN'S NAME (Type) <u>University Hospital Balt. Md.</u>	
23D. ADDRESS <u>University Hospital Balt. Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>3/28/72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Arbutus men park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>	
25B. NAME OF REGISTRAR <u>Blue E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. L. Ruzzo</u>		ADDRESS <u>2222 W. North Ave</u>	

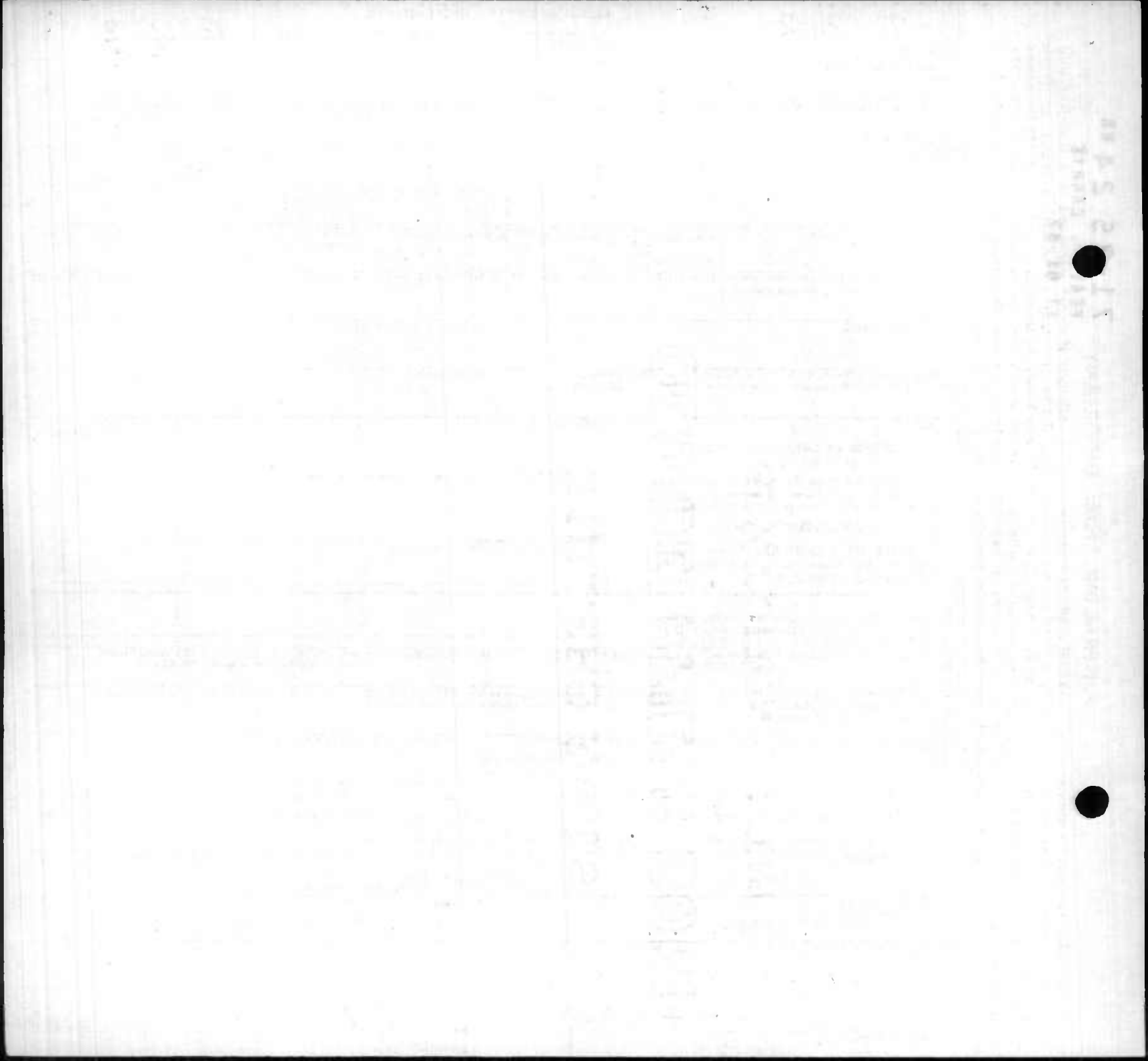


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71-2524 R3
HEALTH DEPT. CARRIE

71-2524 R3

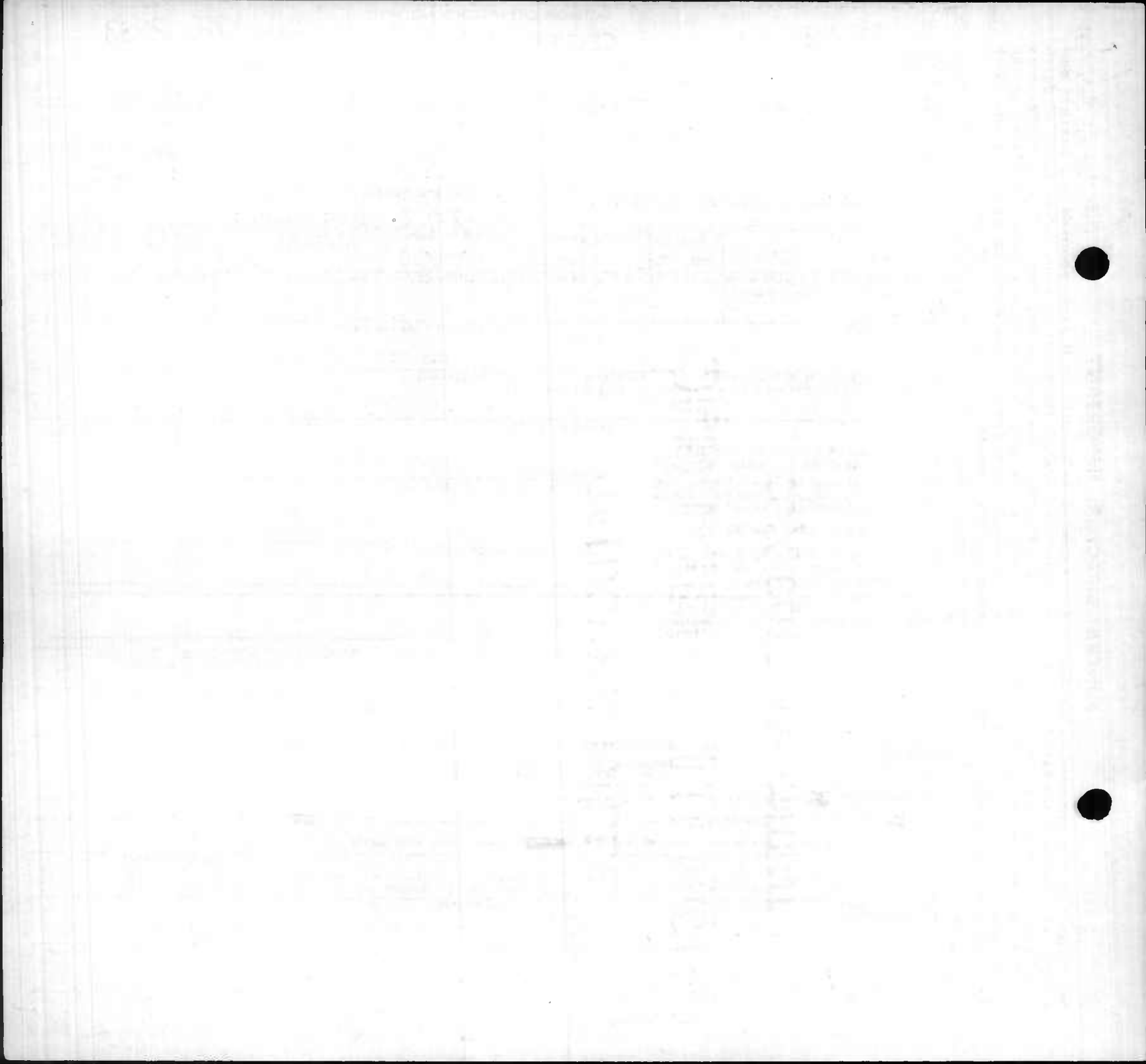
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02982	
72 02982				BIRTH NO.	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) CARRIE HEATH				2. DATE AND HOUR OF DEATH 3-23-72 12:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 704	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY				C. CITY OR TOWN BATLIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 900 N. WASHINGTON STREET	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/01/37		9. AGE (In years last birthday) 34
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Housewife			11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAM HAYES			14. MOTHER'S MAIDEN NAME RUTH JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Hayes - 922 N. Chapel St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Peritonitis			(B) DUE TO, OR AS A CONSEQUENCE OF: Probable Ruptured Viscus Abdomen		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gm (+) cocci sepsis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-20 19 72 to 3-23 19 72 and that (I) (we) last saw the deceased alive on 3-23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Jones				23B. DATE SIGNED 3-23-72	
23C. PHYSICIAN'S NAME (Type) JOHN C. JONES, M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-28-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Westport, Md.		24E. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR John E. Fisher, R.D.		25C. FUNERAL DIRECTOR John H. Flickson - 1129 N. Caroline St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 02983</u>	
C42572 02983				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Chilson, Colleen</u>		2. DATE AND HOUR OF DEATH <u>3/23/72</u> <u>7¹⁵ A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>802</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>1720 N. Port Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/02/08</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>Jeanette Hester</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Naomi Jenkins-1918 N. Castle St.</u>	
18. <u>199.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Disseminated Cancer</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(this hospital)</u> attended the deceased from <u>3/21</u> 19 <u>72</u> to <u>3/23</u> 19 <u>72</u> that <u>(we)</u> last saw the deceased alive on <u>3/23</u> 19 <u>72</u> and that in <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> (did) <u>(not)</u> view the body after death.					
23A. SIGNATURE <u>James N. Ingle, MD</u>				23B. DATE SIGNED <u>3/23/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>James N. Ingle, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>3-29-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A. A. County, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph E. Flickson-1129 N. Caroline St.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 02984
BIRTH NO. 72 02984		1. NAME OF DECEASED (Type or Print) BELT, Willie C		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 3-23-72 3:55 P.M.		
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital Baltimore, Md. 21216		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1607		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX M		6. RACE B		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-16-13		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years last birthday) 58		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		
13. FATHER'S NAME RANNIE BELT		14. MOTHER'S MAIDEN NAME Laura Blanton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 2 34-16-7567		
17. INFORMANT Wellington Blanton		ADDRESS (CONSISTENT) 2723 Oakley Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2ndaries		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3-19-1972 to 3-23-1972 that (I) (we) last saw the deceased alive on 3-23-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE D. S. KARBHARI		23B. DATE SIGNED 3/23/72		23C. PHYSICIAN'S NAME (Type) D. S. KARBHARI
23D. ADDRESS Lutheran Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Removal		
24B. DATE 3-27-72		24C. NAME OF CEMETERY or CREMATORY Cumberland, Virginia		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR McIntosh & McKesson
25D. ADDRESS 1124 N. Caroline St.				

Adm 1/67 to N.H

Q

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 02985					REG. NO. 72 02985				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) John F. Mooss					3/24/72				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.					A. STATE Maryland B. COUNTY Anne Arundel				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Brooklyn Park D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 523 Cedar Hill Road					5200				
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/14	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereore				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Mooss					14. MOTHER'S MAIDEN NAME Anne				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II					16. SOCIAL SECURITY NO. 24-03-2674		17. INFORMANT ADDRESS Dorothy Mooss 523 Cedar Hill Rd.		
18. 4/10/91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction				
(B) DUE TO, OR AS A CONSEQUENCE OF:					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1964 to March 28 1972 , that (I) (we) last saw the deceased alive on March 18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Mario J. Redita MD					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 3/25/72	
23C. PHYSICIAN'S NAME (Type) MARIO J. REDITA MD					23D. ADDRESS 4016 RITCHIE HWY BALTO, MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/28/72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore 19d.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR Robert E. Fisher, MD			25C. FUNERAL DIRECTOR ADDRESS Charles J. Stevens Funeral Home, Inc. 1501 E. FORT AVENUE			

MAR 24 1972

1914

213 Cedar Hill Road

27

1914

213 Cedar Hill Road

27

213 Cedar Hill Road

213 Cedar Hill Road

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02986	
BIRTH NO. 72 02986		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bridget "Bessie" Nossick			2. DATE AND HOUR OF DEATH 3-24-72 5:45 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1444 Richrdson Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2401		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 7-29-1895 9. AGE (In years lost birthday) 76		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feeder For Tobacco House American Tobacco			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Ferguson			14. MOTHER'S MAIDEN NAME Bridget O'Hara		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 24-28-35780		
17. INFORMANT Mildred Stephens			ADDRESS 1444 Richardson St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Intra-abdominal carcinomatosis 1 year ANTECEDENT CAUSES Cancer of pelvic organ 10 years DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 1962		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cancer of pelvic organ		20A. AUTOPSY? (Yes or No) no.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-30-1970 to 3-23-1972, that (I) (we) last saw the deceased alive on 3-23-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. C. Chiu			23B. DATE SIGNED 3-24-72		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) C. C. CHIU, M. D.			23D. ADDRESS 1 E. Randall Street, Baltimore, Md. 21230		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/27/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR 1501 E. Fort Avenue			

Handwritten text, possibly a name or title, located in the upper left quadrant.

Handwritten text, possibly a name or title, located in the upper right quadrant.

Handwritten text, possibly a name or title, located in the middle left quadrant.

Handwritten text, possibly a name or title, located in the middle right quadrant.

Handwritten text, possibly a name or title, located in the lower left quadrant.

Handwritten text, possibly a name or title, located in the lower right quadrant.

Handwritten text, possibly a name or title, located at the bottom left of the page.

Handwritten text, possibly a name or title, located at the bottom left of the page.

C-5001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 02987

BIRTH NO. 72 02987

1. NAME OF DECEASED
(Type or Print)

MARGARET CHEN

2. DATE AND HOUR OF DEATH

3-23-72

3:30 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

341 E 29TH ST.

5. SEX

FEMALE

6. RACE

Chinese

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

01-08-25

9. AGE (In years
last birthday)

47

10. Under 1 Yr.
Months Days11. Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Statistician

10B. KIND OF BUSINESS OR INDUSTRY

Blue Cross & Shield

11. BIRTHPLACE (State or foreign country)

Shang-Hai, China

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Mih, Sibber

14. MOTHER'S MAIDEN NAME

MABEL WOO Mih

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

214-30-6593

17. INFORMANT

Mr. Hok Ming Chen

ADDRESS

Same

18.

746.4-1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

MYOCARDIAL FAILURE

DUE TO, OR AS A CONSEQUENCE OF:

ATRIAL SEPTAL DEFECT

(B) MITRAL / TRICUSPID / AORTIC VALVE DES.

DUE TO, OR AS A CONSEQUENCE OF:

(C) CONGENITAL HEART DISEASE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 HR

7 YRS

47 YRS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

3/22/72

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

TRIPLE VALVE DISEASE

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/3 19 72 to 3/23 19 72
that (I) (we) last saw the deceased alive on 3/23 19 72 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. H. MITCHELL, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/23/72

23C. PHYSICIAN'S
NAME (Type)

W. H. MITCHELL, M.D.

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

3-27-72

24C. NAME of CEMETERY or CREMATORY

Greenmount Crematory

24D. LOCATION

Baltimore,

(City, town, or county)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 24 1972

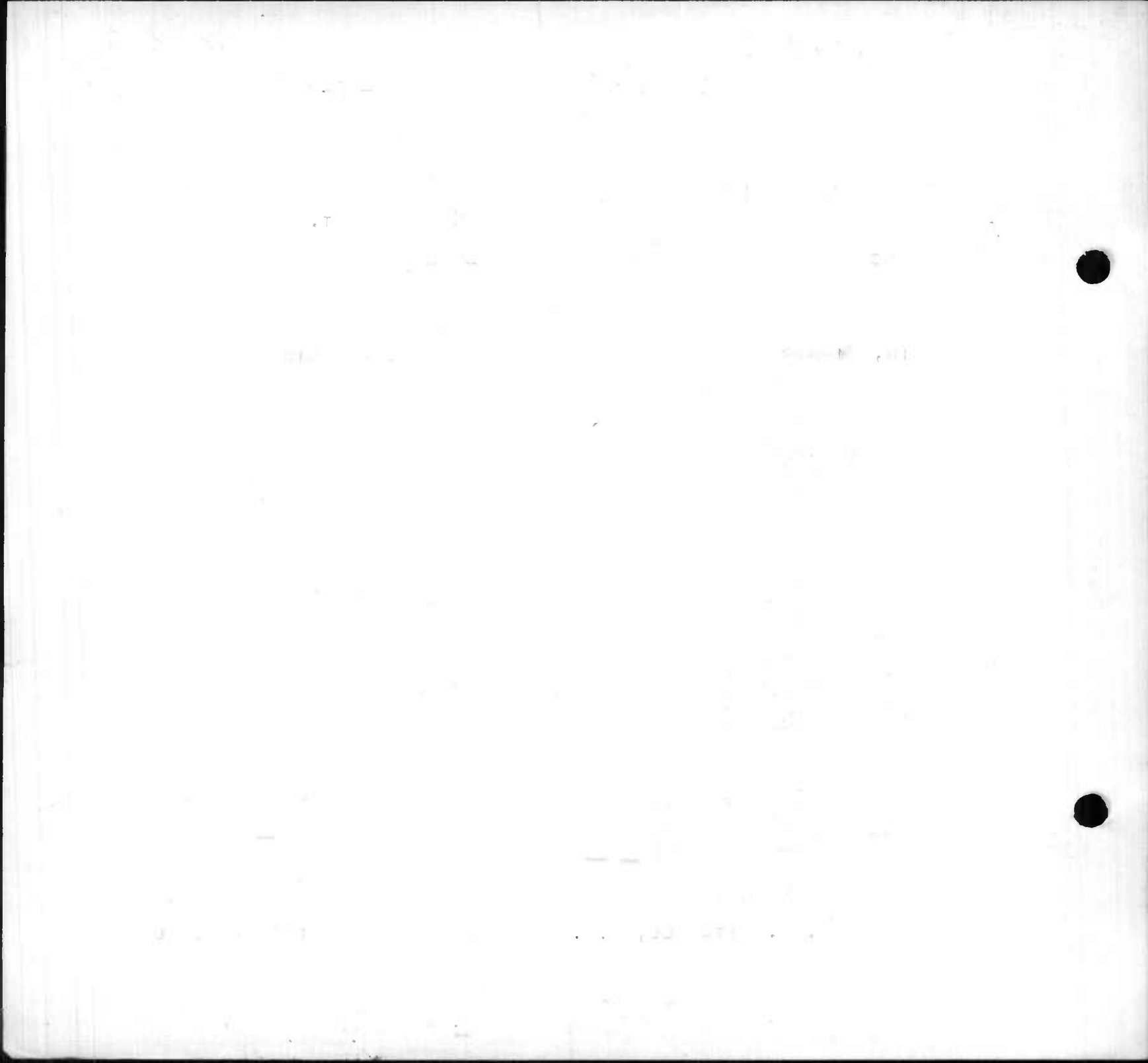
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins Sons Co., 4905 York Rd.
Baltimore, Md. 21212

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 72 02988

BIRTH NO. 72 02988

1. NAME OF DECEASED
(Type or Print)

Mrs. Grace H. Bowen

2. DATE AND HOUR OF DEATH

March 23, 1972 6:15 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

91 700 Keswick
700 W. 40th. St.
Baltimore, Md. 21211

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3215 N. Charles St.

5. SEX

F

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 14, 1891

9. AGE (in years last birthday)

80

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self emp. baby sitter

10B. KIND OF BUSINESS OR INDUSTRY

Personal Service

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

David J. Hunter

14. MOTHER'S MAIDEN NAME

Emma Stinson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-28-4093

17. INFORMANT

Mrs. Leslie H. Peard, Jr.
(Keswick)

ADDRESS

Sidney, Australia

18. 431.9 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebrovascular hemorrhage
Cerebral arteriosclerosis with
encephalomalacia

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 week

2 years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 3 1970 to March 23 1972 that (I) (we) last saw the deceased alive on March 23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W.B. Daniels, Jr. M.D.

DEGREE

Attending ☐ Phys.

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

3/24/72

23C. PHYSICIAN'S NAME (Type)

W.B. DANIELS, Jr. M.D.

DEGREE

23D. ADDRESS

Keswick

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/27/72

24C. NAME of CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION

Pikesville,

(City, town, or county)

Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

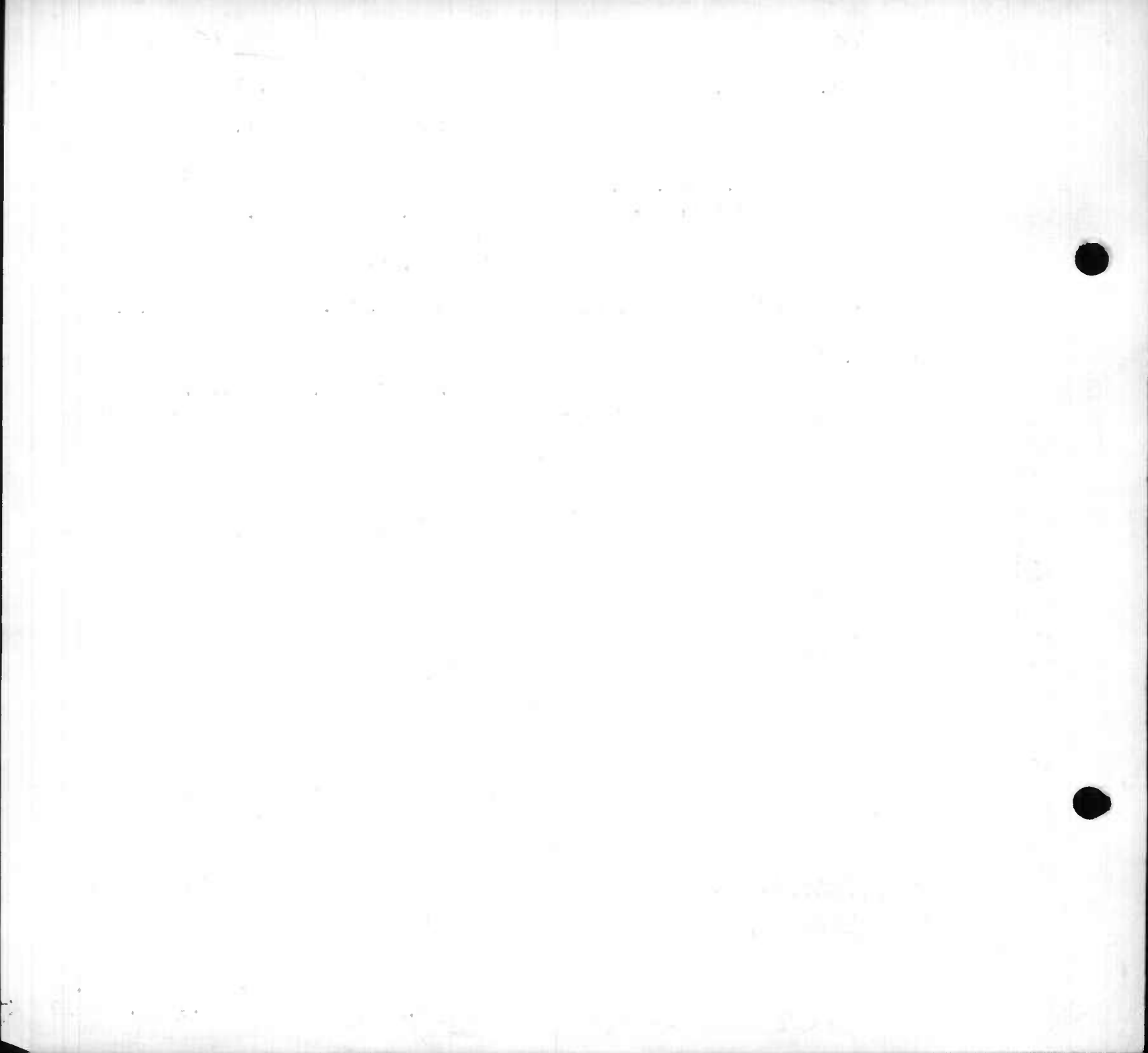
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Balto., Md. 21212

MAR 24 1972 Robert E. Fisher, M.D.

Henry Jenkins & Sons 4905 York Road



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 02989

BIRTH NO. 72 02989

1. NAME OF DECEASED (Type or Print) Bernard J. Brooks				2. DATE AND HOUR OF DEATH 3-24-72 7:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital 38				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 203			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-07	
9. AGE (In years last birthday) 65		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Richard L. Brooks			
14. MOTHER'S MAIDEN NAME Margaret Kennedy				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. A 215-07-3808				17. INFORMANT Mrs. Margaret C. Brooks			
18. ADDRESS (Same)				19. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: 1 hr ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: 6 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gout				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 20 1953 to Mar 27 1972 , that (I) (we) last saw the deceased alive on Mar 13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frederick J. Vollmer M.D.				23B. DATE SIGNED Mar 24 1972		23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer, M. D.	
23D. ADDRESS 6100 York Rd.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3/27/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972	
25B. NAME OF REGISTRAR John E. Baker, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.		25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212			

57

72 02990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02990

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John H. Harris

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

P.M.

3 24 72 420 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

00 615 W. Lafayette St.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

P.M.

3 24 72 420 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD

1703

6. SEX

M

7. RACE

col

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4-26-06

10. AGE (in years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

615 W. Lafayette St.

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Harris

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elnore Harris

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

N/A

17. SOCIAL
SECURITY NO.

18. INFORMANT

Joseph Harris - 25 W. Jackson St.

ADDRESS

Richmond, Va.

19.

571.81

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Fatty alteration

of liver

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz MD

Deputy
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3.25.72

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-27-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial

24D. LOCATION (City, town, or county)

Baltimore, MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 24 1972

25B. NAME OF REGISTRAR

Robert E. Spitz, MD

25C. FUNERAL DIRECTOR

Hortons Byett F.H. 1701 - Laurens St.

ADDRESS

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY 60322

4-21-02
131

1/2

Thomas Harris
Thomas Harris
Joseph Harris - 22 W. 1st St.

Original sent to Robert L. Harris
10-10-2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02991	
BIRTH NO. 72 02991		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Cochran</u>		2. DATE AND HOUR OF DEATH <u>3-24-72</u> <u>3 15 AM.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Providence Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>D.S. Maryland</u> B. COUNTY <u>1504</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2015 Bentalou St</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-57</u>	9. AGE (in years last birthday) <u>84</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Annie Howard</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>911-18-9993</u>		17. INFORMANT <u>Alma Randolph</u> ADDRESS <u>2015-Bentalou St</u>	
18. <u>412.4-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD w/ CHF & Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Wertz</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. G. MERCADO</u>		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-28-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) <u>Balto, Md</u>		24E. (State) _____			
25A. DATE REG. BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>701 - Address St</u>	

James Roberts

James Roberts, M.D.

James Roberts, M.D.

James Roberts, M.D.

1
W 426

72 02992

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 02992

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Willie Henry Walker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 23 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 23 72 3:24 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY BALTO. 5300	
9. DATE OF BIRTH 5-2-06		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) Farmville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Walker		14. STREET AND NUMBER 665 N. Avondale Road	
15. MOTHER'S MAIDEN NAME Agnes James		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N/A	
17. SOCIAL SECURITY NO. 227-07-4899		18. INFORMANT ADDRESS Mrs. Velma Gordon-228 S. 7th St. Neward, N. J.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. DATE OF OPERATION 2		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. HOW DID INJURY OCCUR?		22H. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	

St. Thomas

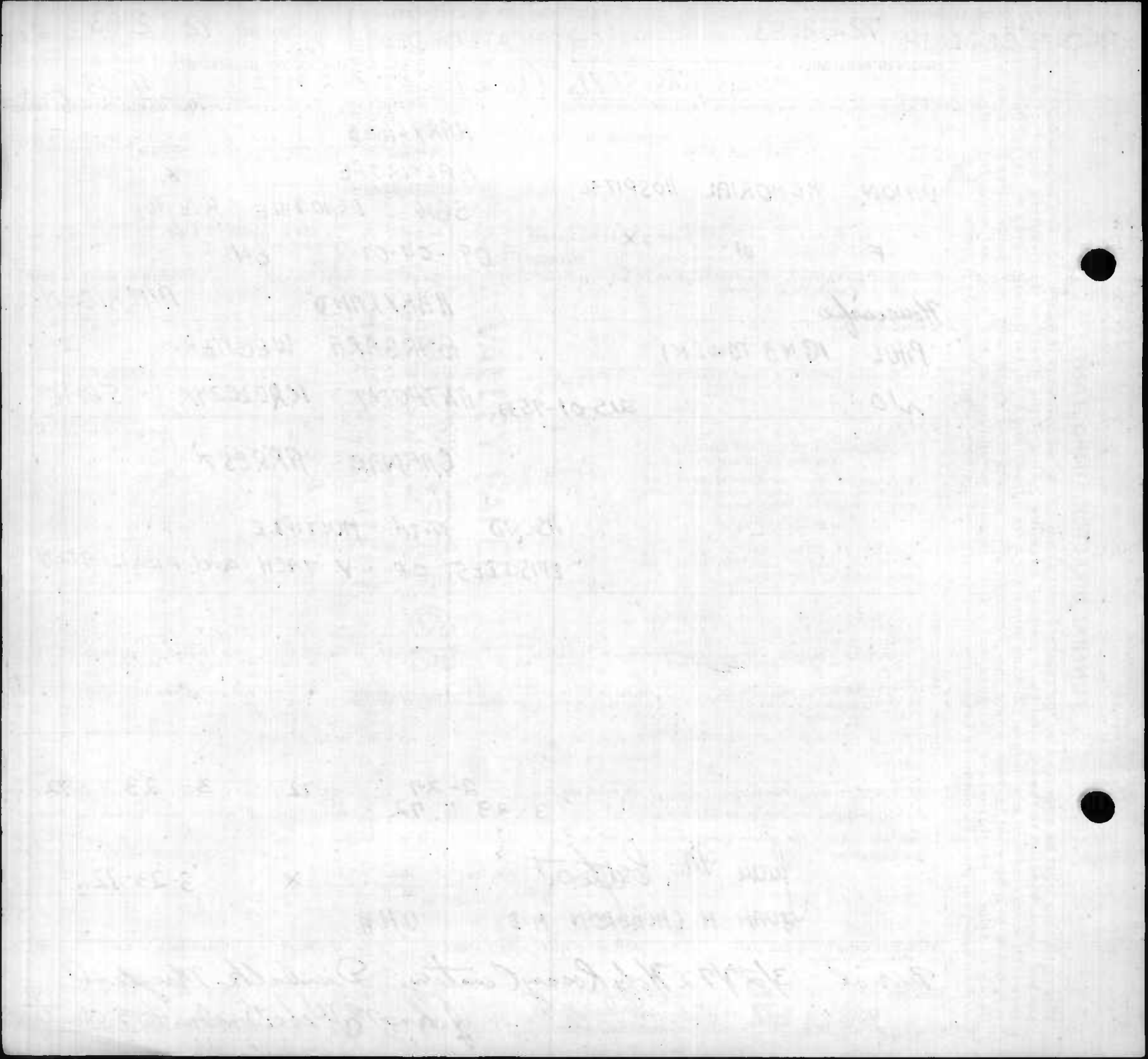
July 1 - 7-77 C. Johnson City

Office 2000 E. 17th Avenue

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

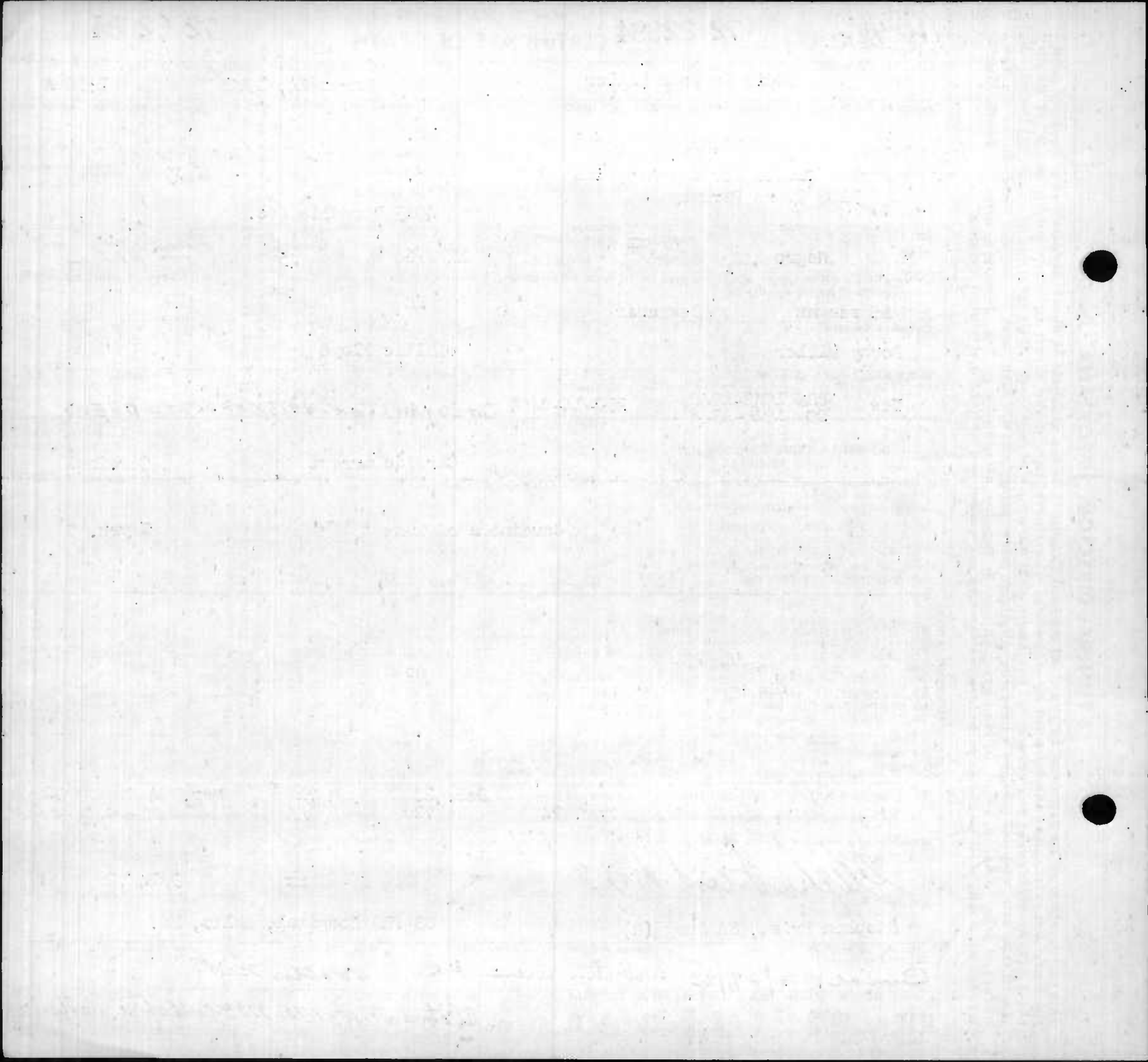
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02993	
72 02993				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROSE(C.) KROLCZYK (Kane)		3-23-72 4:25 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				A. STATE MARYLAND	
				B. COUNTY 2734	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3616 ECHO LALE AVENUE	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09-04-07	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME PAUL IGNA TOWSKI		14. MOTHER'S MAIDEN NAME BARBARA WEGNER		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-9533		17. INFORMANT ANTHONY KROLCZYK	
				ADDRESS SAME	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST	
				(B) ASCVD WITH MULTIPLE DUE TO, OR AS A CONSEQUENCE OF:	
				(C) EPISODES OF V. TACH AND FIBRILLATION	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-27 19 72 to 3-23 19 72 , that (I) (we) last saw the deceased alive on 3-23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Juan M. Calderon</i>				23B. DATE SIGNED 3-23-72	
23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON M.D.				23D. ADDRESS UHA	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		3/27/72		Not a Rosary Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME of REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>John M. Weber + Son Inc. 401 S. Chester</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. M-460		72 02994		CERTIFICATE OF DEATH		REG. NO. 72 02994	
1. NAME OF DECEASED (Type or Print) Eddie Sampson Miller				2. DATE AND HOUR OF DEATH March 24, 1972				2:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2X 3100 Wyman Parkway				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2798				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M				6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/8/26		9. AGE (In years last birthday) 45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AB seaman				10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) NC				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Miller				14. MOTHER'S MAIDEN NAME Lillie Floyd							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1942-1946 CG 1946-1948				16. SOCIAL SECURITY NO. 230-14-6484		17. INFORMANT DAISY MILLER - 4913 CORDELIA AVE.				ADDRESS	
18. 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of lung				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal 2 yrs. ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 162.1				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (Y) (this hospital) attended the deceased from Dec. 28 19 71 to Mar. 24 19 72 , that (Y) (we) lost saw the deceased alive on Mar. 24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Stephen Frist MD DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/24/72	
23C. PHYSICIAN'S NAME (Type) Stephen Frist, SA Surg (R) DEGREE								23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 3/29/72		24C. NAME of CEMETERY or CREMATORY Arbiter mem. PK.				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972				25B. NAME OF REGISTRAR Robert E. Zuber MD.				25C. FUNERAL DIRECTOR Chapman F. G.			
ADDRESS 1701 M & Culloden St. Balto. Md.											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 02995	
B-452 72 02995				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BLANKS, MR. HECTOR THOMAS		2. DATE AND HOUR OF DEATH MARCH 24, 1972 1 3:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME + HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 604	
5. SEX M		6. RACE A W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY FARMER		8. DATE OF BIRTH 12-21-92 9. AGE (in years last birthday) 79	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN BLANKS	
14. MOTHER'S MAIDEN NAME SARAH BELL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 237-38-5355	
17. INFORMANT EVADER DURDEN -		ADDRESS SARIE		18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Arteriosclerosis		(B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS; GENERALIZED MANY YRS.		(C) _____	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from MARCH 12 19 72 to MARCH 24 19 72 that (I) (we) last saw the deceased alive on MARCH 24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ma. Elena V. Mangay M.D. DEGREE	
23B. DATE SIGNED 3-24-72		23C. PHYSICIAN'S NAME (Type) MA. ELENA V. MANGAY M.D. DEGREE		23D. ADDRESS 100 N BROADWAY, BALTIMORE, MD 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/27/72		24C. NAME OF CEMETERY OR CREMATORY TEN MILE CENTER	
24D. LOCATION (City, town, or county) (State) ROBINSON COUNTY N.C.		25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR 0000	
25C. FUNERAL DIRECTOR BIGGS FUNERAL HOME LUMBERTON N.C.		ADDRESS			

35. 5. 1942

35. 5. 1942

Letter to the Editor

Dear Sir,

I am writing to you regarding the

letter of the 21st inst.

which you received from me.

I am sorry that I cannot

reply to you more fully.

I am, Sir, very truly yours,

Yours faithfully,

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

Letter to the Editor

Dear Sir,

I am writing to you regarding the

letter of the 21st inst.

which you received from me.

I am sorry that I cannot

reply to you more fully.

I am, Sir, very truly yours,

Yours faithfully,

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

W. J. B. B. B.

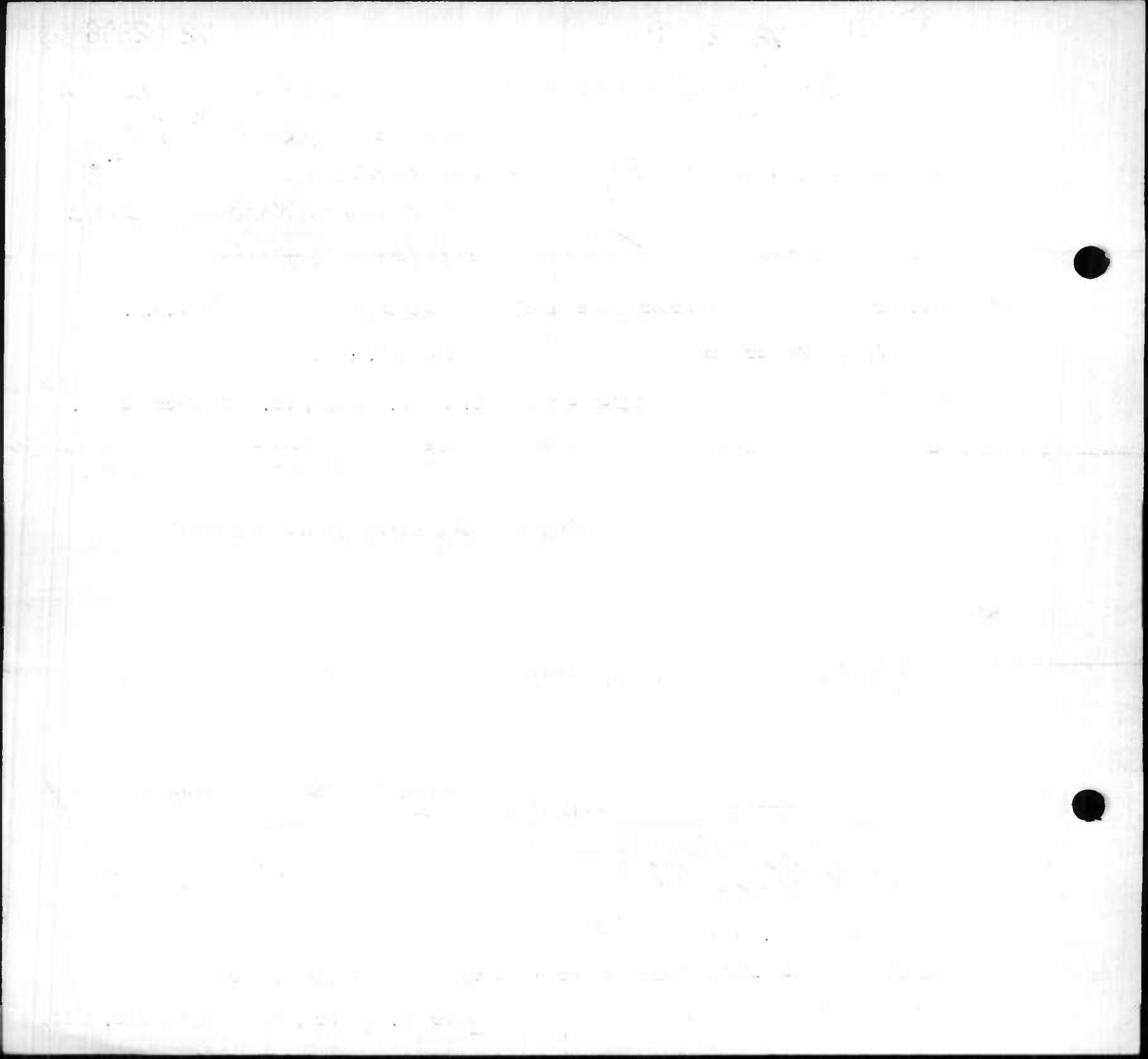
W. J. B. B. B.

W. J. B. B. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

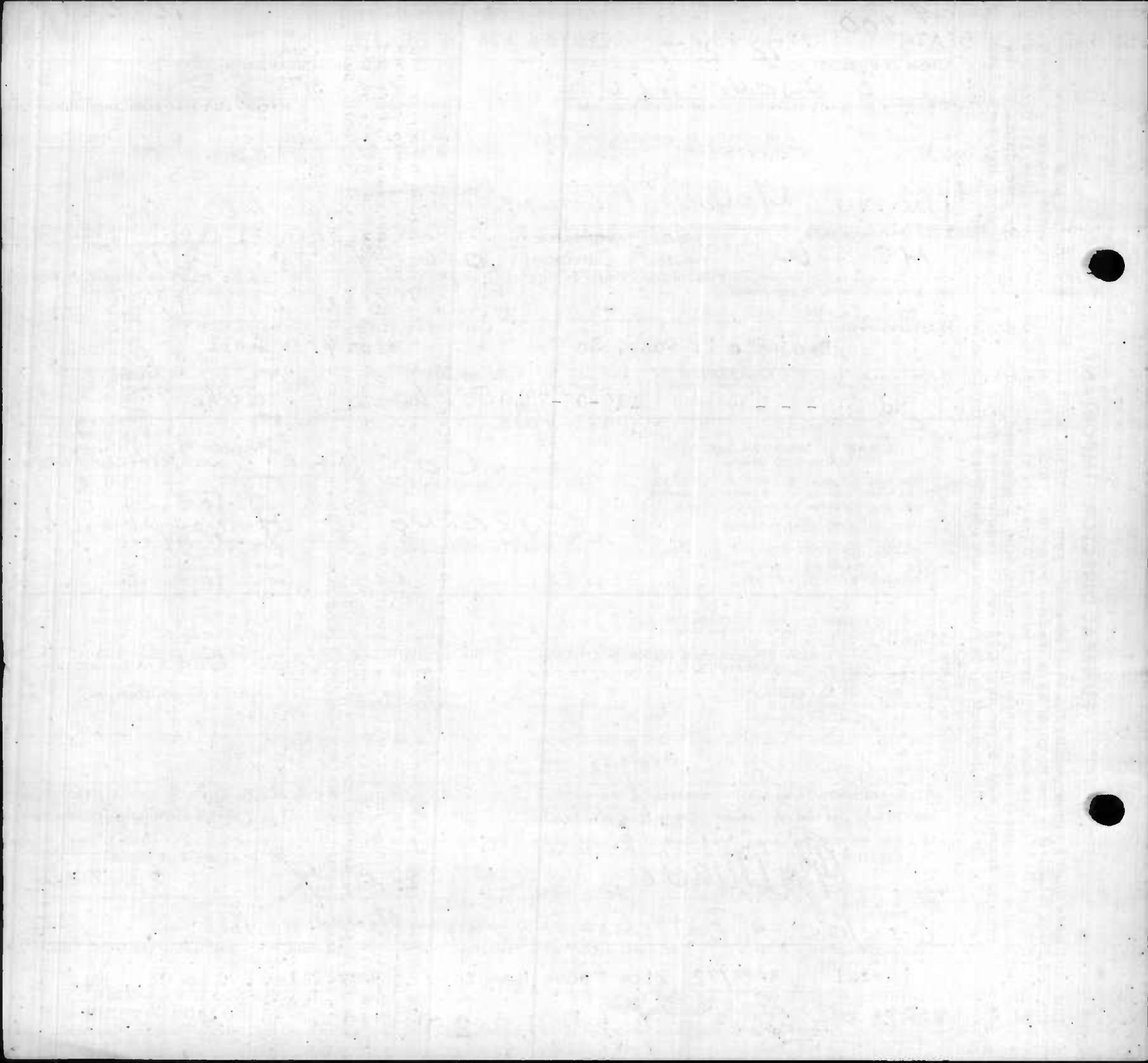
D-250		72 02996		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 02996	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DOXZON, DOROTHY JONES			
2. DATE AND HOUR OF DEATH 3/23/72 12⁴⁰ A M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE				C. CITY OR TOWN ANNAPOLIS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 807 RIVERVIEW ROAD				21012			
5. SEX F	6. RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/1/29	9. AGE (in years last birthday) 42	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Charter House Motel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fenner Newman				14. MOTHER'S MAIDEN NAME Alice R. Pool			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 213-24-2295		17. INFORMANT Mr. Roy E. Doxzon, Jr. 807 Riverview Rd.			
18. 83.0 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SYMPTOMATIC X 5 MOS.			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF: (B) MUCINOUS ADENOCARCINOMA, OVARY DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 1/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLOR. FOR ABD. MASS		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN. 7 19 72 to MARCH 23 19 72 that (I) (we) last saw the deceased alive on MARCH 23 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Daniel Bakal, M.D.				23B. DATE SIGNED 3/23/72		23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-1972		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72-02997</u>	
7-200		72 02997	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>BENJAMIN F. FUSS</u>		2. DATE AND HOUR OF DEATH <u>3-23-72</u> <u>8:00</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1348</u>	
5. SEX <u>M</u> 6. RACE <u>W</u>		C. CITY OR TOWN <u>BAITIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>1316 MORLING AV.</u>	
8. DATE OF BIRTH <u>10-6-24</u> 9. AGE (In years last birthday) <u>78</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin F. Fuss, Sr</u>		14. MOTHER'S MAIDEN NAME <u>Nina G. Gossell</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-7840</u>	
17. INFORMANT <u>Richard F. Cole</u>		ADDRESS <u>1420 MORLING</u>	
18. <u>150X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ca cachexia - Malnutrition</u> <u>CARCINOMA of Esophagus.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2-22</u> 19 <u>72</u> to <u>3-23</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>3-23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Carlo A. Battilana</u> MD		23B. DATE SIGNED <u>3-23-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Carlo A. Battilana MD</u>		23D. ADDRESS <u>Union Memorial Hos</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/27/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Rayville, Balto Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>7-2000</u>	
25C. FUNERAL DIRECTOR <u>Worwings</u>		ADDRESS <u>3818 Roland Avenue</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-300		72 02998		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 02998	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>Hilda Lloyd</u>				2. DATE AND HOUR OF DEATH <u>3/21/72</u> <u>12:45 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2301</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hosp.</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-28-07</u> <u>69</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK STUEBER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA RAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-28-6290T</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u> <u>BCH: Records</u>			
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Embolism, MI</u> (B) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>			
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>2</u> (this hospital) attended the deceased from <u>3/12</u> 19 <u>72</u> to <u>3/21</u> 19 <u>72</u> , that (I) <u>last</u> saw the deceased alive on <u>3/21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Nicholas Iliff</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/21/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Nicholas ILIFF</u>				23D. ADDRESS <u>BCH</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>3-23-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAR 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>1300 F STREET</u>		ADDRESS <u>BALTO. 21230</u>	

C-452

72 02999 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 02999

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT F. COLLINS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) SOUTH BALTO. GENERAL HOSPITAL (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour March 22, 1972 10:45 A.M.			
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 8, 1915		10. AGE (In years lost birthday) 57 58		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Contractor		14B. KIND OF BUSINESS OR INDUSTRY Self Employed		13. FATHER'S NAME John F. Collins		15. MOTHER'S MAIDEN NAME Ollie Riddle	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Albert F. Collins, Jr.		ADDRESS 134 Hatings Street Balto., Md. 21230	
19. 43071 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rupture of aneurysm of circle of willis			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. DATE SIGNED 3/22/72 EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-25-72		24C. NAME of CEMETERY or CREMATORY Meadowdale Memorial Park		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR McCully Funeral Home ADDRESS 130 East 8th Avenue Balto., Md. 21230			

1. Marriage certificate--License No.289--dated 8/6/61 in Baltimore City
Albert F.Collins married Georgie M.Johnson
2. Certified statement from Clerks of Circuit Court of Balto.City and Circuit Court No.2
of Baltimore City, respectively, that their records do NOT disclose that an application
for divorce was filed therein by any of the parties noted above in "1".

SMN



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 03000	
S-530 72 03000		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HENRIETTA R. SMITH		2. DATE AND HOUR OF DEATH March 23, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2005	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Self Employed	9. AGE (In years last birthday) 85
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin Scott		14. MOTHER'S MAIDEN NAME Ida Scott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3484	
17. INFORMANT Mrs. Mildred Schilling, 2229 W. Pratt Street		ADDRESS 21223	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebrovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Dementia	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/21 19 72 to March 23 19 72 , that (I) (we) last saw the deceased alive on 3/21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George Vash		23B. DATE SIGNED 3/24/72	
23C. PHYSICIAN'S NAME (Type) George Vash		23D. ADDRESS 206 S. Gilmore Street, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-27-1972	
24C. NAME OF CEMETERY OR CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAR 24 1972		25B. NAME OF REGISTRAR Robert E. Hubbard	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

